EXAMINING OBAMACARE'S PROBLEM-FILLED STATE EXCHANGES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS

AND THE

SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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EXAMINING OBAMACARE'S PROBLEM-FILLED STATE EXCHANGES

Thursday, April 3, 2014

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS, JOINT WITH THE SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE AND ENTITLEMENTS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2154, Rayburn House Office Building, Hon. James Lankford [chairman of the House Subcommittee on Energy Policy, Health Care and Entitlements] presiding.

Present from Subcommittee on Economic Growth, Job Creation and Regulatory Affairs: Representatives Jordan, DeSantis, McHenry, Gosar, Meadows, Bentivolio, Cartwright, and Connolly.

Present from Subcommittee on Energy Policy, Health Care and Entitlements: Representatives Lankford, Gosar, McHenry, Jordan, Walberg, Massie, Speier, Norton, Cartwright, and Lujan Grisham.

Also Present: Representatives Issa, Cummings, Maloney, and Hanabusa.

Staff Present: Brian Blase, Majority Professional Staff Member; Molly Boyl, Majority Deputy General Counsel and Parliamentarian; Caitlin Carroll, Majority Press Secretary; John Cuaderes, Majority Deputy Staff Director; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Linda Good, Majority Chief Clerk; Meinan Goto, Majority Professional Staff Member; Christopher Hixon, Majority Chief Counsel of Oversight; Michael R. Kiko, Majority Legislative Assistant; Mark D. Marin, Majority Deputy Staff Director for Oversight; Emily Martin, Majority Counsel; Laura L. Rush, Majority Deputy Chief Clerk; Jessica Seale, Majority Digital Director; Matthew Tallmer, Majority Investigator; Sarah Vance, Majority Assistant Clerk; Tamara Alexander, Minority Counsel; Jedd Bellman, Minority Counsel; Aryele Bradford, Minority Press Secretary; Susanne Sachsman Grooms, Minority Deputy Staff Director/Chief Counsel; Jennifer Hoffman, Minority Communications Director; Elisa LaNier, Minority Director of Operations; Una Lee, Minority Counsel; Juan McCullum, Minority Clerk; Suzanne Owen, Minority Senior Policy Advisor; Mark Stephenson, Minority Director of Legislation; and Cecelia Thomas, Minority Counsel.

Mr. LANKFORD. The committee will come to order.

I would like to begin this hearing by stating the Oversight Committee's mission statement.

We exist to secure two fundamental principles: first, Americans have the right to know the money Washington takes from them is well spent and, second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights.

Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have the right to know what they will get from their Government. We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

Good morning, everyone. This is a conversation today about the Affordable Health Care Act and about, specifically, the State exchanges. Four years ago the President's health care law was passed. In selling his law to the American people, the President made several promises. He promised the people they would be able to keep the coverage and doctors they liked; he promised the premiums for the average family would go to about $2,500.

Four years later reality is setting in. Over 5 million Americans have received cancellation notices from their insurance companies and millions more have found out the doctors they liked were no longer covered by that plan. Rather than premiums going down, premiums for family has increased in many areas of the Country since passage of the law.

Just this week, the Bureau of Economic Analysis reported that health care spending growth hit a 10-year high. We were also told that ObamaCare would be good for the Nation's economy. The truth is that in order to minimize the negative exposure to ObamaCare's costly mandates and taxes, employers were forced to lay off some workers and reduce some full-time workers to part-time.

The Congressional Budget Office estimated that within a few years ObamaCare would reduce employment and activities in employment by 2.5 million full-time job equivalents. ObamaCare dramatically increases Federal Government spending at a time when the Federal Government continues to run a massive deficit. According to the CBO, ObamaCare spends nearly $2 trillion over th next decade. To pay for all this, there are 20 new taxes and significant cuts to the Medicare Advantage program.

Despite the Federal Government spending all this money, more than 80 percent of the people who were uninsured before ObamaCare took effect are still uninsured today.

In addition to the negative economic effects of the law, the Administration has implemented extra legal fashion 21 different parts of the law changes. For example, in response to public anger over the President's broken promise about health insurance, the Administration unilaterally allowed insurers to renew non-grandfathered policies for an additional year. Last month, the Administration extended this policy until after the 2016 election. This change by the Administration is just part of a pattern of extra legal actions aimed at insulating the law's supporters from unpopular and inconvenient parts of the law at the expense of taxpayers.

While I welcome policy changes that reduce the burden of ObamaCare's costly mandates and give consumers greater choice, the Administration set a dangerous precedent by going around Congress to rewrite parts of the law that are politically troubling.

The Obama Administration's rewriting of the law has introduced even greater uncertainty in the health insurance market and may lead to higher premiums in 2015 and beyond. Recently, WellPoint, one of the largest insurers participating in ObamaCare's exchanges, predicted double-digit premium increases in 2015. Just this week, analysis at Moody's predicted that premiums will continue to increase because of the way the Administration has carried out the law.

While there are many issues we can and will explore about ObamaCare in the days ahead, the topics of today's hearing are State exchanges. Representatives from the States of Hawaii, Maryland, Massachusetts, Minnesota, Oregon, and California are here today. Residents in these States were forced to use an error-ridden Website. Many people who thought they had successfully enrolled found out that the insurance plan they had chosen had not received any enrollment information from the exchange.

State residents were also working through the same issues that are on the Federal side. And while States have worked incredibly hard, and we are grateful to your service to the people of the States that you represent, you are also struggling with some of the Federal regulations and some of the delays that are coming down as well.

Multiple problems with the ObamaCare Websites built by different States and by the different exchanges raise several questions: How is it possible, after three and a half years and spending hundreds of millions of dollars of taxpayer funds, that so many different exchanges had an incredibly difficult time putting together a Website? Second, what was the effective delay in changing guidance from the Obama Administration on the construction of the State exchanges? Third, where was Federal oversight of the projects? How could so many State exchanges have such a difficulty all at the same time? And, finally, how many more taxpayer dollars will be requested to bail out any troubled State exchanges in the years ahead?

Congress has an important oversight role: to ensure that taxpayer funds are spent wisely and effectively. I welcome the witnesses here and I really do appreciate you coming, being a part of this conversation. You have things to be able to contribute to this conversation that we cannot know until we get a chance to be able to hear from you, so glad to be able to have that conversation with you.

I now recognize the distinguished ranking member, the gentlelady from California, Ms. Speier, for her opening statement.

Ms. SPEIER. Thank you, Mr. Chairman and to all the witnesses who have traveled long distances to be with us today.

Now that we have surpassed the goal established two and a half years ago for enrollment, with more than 7 million Americans enrolled in the ACA, Republicans are as determined today as ever to try and rip it apart. Seven million Americans must be wrong.

The reality is that the latest enrollment numbers prove that there is a genuine demand amongst the American people for affordable health care. This 7 million doesn't even include enrollment surges that took place in the 15 States, including California, running their own exchanges.

Republicans today won't be focusing on these successes, or even conceding that their predictions thus far have been as reliable as a fortune-teller at a carnival. Many Republicans have voiced their certainty that the ACA would fail. They said that the 7 million goal was impossible. Several months ago, Chairman Issa said, "It is time for the President to finally acknowledge ObamaCare isn't working and to delay the law in fairness to families and individuals."

Today is the committee's twenty-sixth hearing on the ACA, and this week, on the floor, we voted for the fifty-second time to repeal it.

Like all historic and transformative pieces of legislation, the rollout of the ACA has been challenging and far from smooth. But Republicans have contended from the beginning that there is no meaningful role for the Federal Government in health care.

Let's remember, though, how the market has handled health care in the past. The market allowed insurers to rescind your coverage if you got sick and deny you coverage if you had a preexisting condition. The unregulated market also allowed insurers to charge women more just for being women.

Let's all remember how the market determined premiums. Before the ACA, with the exception of the recession, premiums grew by double digits year after year. Since the law has gone into effect, we have seen dramatic declines in the rise of premiums. This is the real story of the impact of the ACA, and I ask you to look at this chart. This is profound. And if anything speaks to the importance of the ACA, it is that premiums have declined dramatically as a result of this effort.

I agree with my colleagues on the other side that the ACA should be the subject of scrutiny by Congress and the oversight of this committee, but the consistently partisan and one-sided approach has been all about tearing the program down, not fixing it. The preparation for this hearing only provided the latest example of how this committee seeks to undermine the efforts of States and the Administration to implement the law.

Today we will hear testimony from Ms. Jean Yang, Executive Director of the Massachusetts Health Insurance Exchange. Massachusetts has experienced its own set of Website issues and requested to send Ms. Yang's highly qualified colleague to this hearing instead of Ms. Yang so that she could stay in Massachusetts and continue her work in fixing the Website. However, upon hearing about the change in witnesses, the chairman of the full committee threatened to issue a subpoena.

I would like to apologize on behalf of this committee to you, Ms. Yang, and to the people of Massachusetts for the actions to bully you into testifying today.

What this committee should be focusing on is what we have to do in the future to contain costs and how we can share the best practices by successful States like California, Connecticut, Ken-

tucky, and New York with the States that are still struggling. A truly balanced hearing would have looked at more than just one story of State-based exchange success. If someone from Kentucky's exchange had been invited to testify, I am sure they would have wanted to tell the committee that a preliminary analysis found that approximately 75 percent of their enrollees were previously uninsured before signing up through the exchange, and that 49 percent of their enrollees are under the age of 35, or that by the end of the enrollment period over 370,000 Kentucky citizens now have health insurance that didn't have it before.

To that end, I am so glad to have Peter Lee, the Executive Director of the California Exchange, Covered California, here to testify as Minority witness and to bring some good news and balance to this discussion.

At the end of March 31st, over 1.2 million Californians have signed up for private health insurance through the exchange. This number greatly surpassed California's baseline projection of 580,000 and the enhanced projection of 830,000 for the entire open enrollment period. California's Medicaid Program, Medi-Cal, enrolled approximately 1.93 million, and an additional 800,000 were found likely eligible. This brings the total of all Californians enrolled through Medi-Cal and the exchange to almost 4 million people, and insurance companies in California are reporting that 85 percent of the enrollees have paid their first month's premium.

California has refused to accept the exchange's current success as the now continually updating policies such as efforts to increase enrollment in the Latino community.

Mr. Lee, I look forward to hearing more from you today about the improvements that California plans to make and how you can help other States.

Mr. Chairman, as you know, I value our relationship. We have common interests that we have discussed many times, and I know we can put our heads together and come up with new hearing topics that conduct real oversight. For example, I sent a letter to Chairman Issa yesterday requesting that the committee investigate and hold a hearing on the alleged Medicare, Medicaid, and Tricare fraud perpetrated by Health Management Associates, a for-profit hospital chain that allegedly ripped off taxpayers for more than $600 million. That should be the work of this committee.

I look forward to hearing the testimony of all the witnesses present today, and thank you for being here.

Mr. LANKFORD. I ask unanimous consent that our colleague from Hawaii, Ms. Hanabusa be allowed to participate in today's hearing. Without objection, so ordered.

I would like to recognize the chairman on the Subcommittee on Economic Growth, Mr. Jordan, for his opening statement.

Mr. JORDAN. Thank you, Mr. Chairman. I would, if I could, just ask unanimous consent my opening statement be put in the record.

Mr. LANKFORD. Without objection.

Mr. JORDAN. We have several witnesses. I want to thank you for having this hearing.

Let's just remember all the false claims that have been made about the Affordable Health Care Act. I think sometimes it is good just to go back and put some context on this.

If you like your plan, you can keep it. False.

If you like your doctors, you can keep them. False.

Premiums will go down. False.

Premiums will go down an average of $2,500, the Administration said. False.

The Website will work. False.

The Website is secure. False.

We have had countless hearings to dispel all these claims made by the Administration and now, today, Mr. Chairman, we are going to hear about the dismal performance of the State exchanges, again underscoring how poorly this law has operated, how bad it is, and why we need to change it.

I just want to thank you for putting this hearing together. I look forward to hearing from our witnesses. More importantly, I look forward to asking questions of our witnesses about these six State exchanges and the overall impact this law has had on the American people.

With that, I would yield back.

Mr. LANKFORD. Thank you.

I recognize the ranking member of the Subcommittee on Economic Growth, Mr. Cartwright, for an opening statement.

Mr. CARTWRIGHT. Thank you, Chairman Lankford, and Chairman Jordan as well.

This marks the twenty-sixth hearing this committee has held on the ACA. Over the course of 25 hearings you would think that every member on this committee on both sides of the aisle would have been working tirelessly to guarantee that each and every one of their constituents had access to affordable health care. You would also think that these hearings would have consisted of a bipartisan effort to find ways to fix Healthcare.gov and that actual oversight would eventually take place. This is the Oversight Committee.

It saddens me to say that in 25 hearings none of these things actually happened, and I am afraid that today isn't going to be any different. In this committee, and throughout this Congress, health care has become a divisive, partisan issue. Instead of offering solutions to ensure that constituents have access to universal health care, this House has, instead, held 54 votes to repeal the Affordable Health Care Act. Some of my colleagues have also run misleading and oftentimes outright false advertisements designed to frighten their constituents from signing up on the exchanges, as opposed to educating them on the realities of the ACA.

I am very proud that congressional Democrats have held more than 400 events in their districts at home in an effort to educate constituencies on the ACA. I have had five of them myself in my district. I would also like to commend my fellow Democrats for all their efforts in ensuring that their constituents are afforded this same kind of information.

This hearing has been called in order to examine the State health insurance exchanges under the ACA. California has one of the most successful State exchanges, with more than a million individuals having signed up for private health insurance plans through its exchange. Other States such as New York, Rhode Island, and Connecticut have also experienced success with imple-

menting their State exchanges. I am very grateful that Mr. Peter Lee is here with us today to speak regarding California's State exchange and provide much needed balance to this hearing today.

I do wish that New York, Rhode Island, and Connecticut were also included today so we could hear about their best practices. I also wish that Pennsylvania had its own State exchange so that my constituents could have had the same tailored access that these States have. While I wish the governor of Pennsylvania had originally accepted the Administration's generous offer for Medicaid expansion, it is my hope that the two sides can still agree on a plan and expand Medicaid for the more than 520,000 Pennsylvanians that would benefit from that kind of expansion.

The high demand for the quality affordable health care available under the Affordable Health Care Act is real; it is evident by the recently released enrollment figures showing 7.1 million people have signed up for the private health insurance plans using both the Federal and State exchanges, beating both the Administration's own goal and popular expectations. If the market demand isn't enough evidence the health care bill is more popular than ever, about half of all Americans now support the law, despite the misinformation being disseminated over the last four years.

And I want to say I am glad that many, many more people in places like Oregon, Maryland, California, Massachusetts, Hawaii, and Minnesota have health insurance than they did prior to October 1, 2013, and I am interested in hearing about how these States did this despite glitches with the rollout in each of those States. And I look forward to hearing about the best practices from the State of California, from which I think we can all learn a lot.

I welcome our witnesses and thank them for taking the time to be with us today.

I yield back, Mr. Chairman.

Mr. LANKFORD. I would like to recognize the chairman of the full committee, Mr. Issa, for his opening statement or any statement that he would like to make.

Mr. ISSA. Thank you, Mr. Chairman. Congressman Lankford, I want to thank you for the work you have done on the details of the flaws in Healthcare.gov and in the overall legislation.

I ask unanimous consent that my entire opening statement be placed in the record.

Mr. LANKFORD. Without objection.

Mr. ISSA. Mr. Lee, I welcome you here. It is particularly important, as a Californian, to have California represented here because both the best and the worst, perhaps, will be seen in looking at the largest State in the Union.

We often turn divisive, partisan legislation into divisive, partisan oversight. Mr. Cartwright, Ms. Speier have made that clear by talking about Republicans this, Republicans that. I have called or authorized every one of those many hearings they alluded to, and I am proud we did it and I am only sorry we didn't do more and sooner. Ultimately, about half of America's Federal spending will be related to health care, Medicare, Medicaid, Medicaid do eligibles for our seniors, and obviously the growth related to subsidizing the Affordable Health Care Act represent the largest single bulk of the budget today, and that over a trillion dollars is the area in which

we have no real control over the rise in those costs unless we implement changes that drive the cost of delivery down.

Long before President Obama became a Senator we had problems with health care. I think Republicans and Democrats need to recognize that Medicare and Medicaid have been part of the problem, not just part of the solution.

Just a few days ago, by voice vote, almost a cowardly act in many ways, we did what was called the doc fix. The doc fix is based on a decade, well, 1997, I guess, old mandate that somehow we were going to lower costs through some congressional magic and fiat. Every year we recognize that it doesn't work and that if we don't suddenly come up with billions of dollars of new money, our doctors will be underpaid by, now, about 25 percent of what apparently we believe is fair.

And I use that as an example of a Clinton era Republican House and Senate attempt to fix health care, and I do it because this committee has a solemn responsibility to deal in real facts, in real costs, and in real savings. That has not been the case for people on both sides of the aisle for decades.

The Affordable Health Care Act is well-intended, I believe, but it has had many flaws. One of them that we will see today is fairly straightforward: instead of doing a single Website in which everyone fed in, spending $700 million, $800 million, $1 billion, $1.5 billion, $2 billion, some enormous amount of money to create a network, what we did is we issued out large grants. In the case of California, the number I have in front of me is $1,065,212,950 in grants. In the case of Hawaii I am told it is about $200 million just to establish the Website.

Let's understand something here today. Whether you voted for the Affordable Health Care Act or you didn't, redundant programs throughout most of 50 States that issued hundreds of millions of dollars per State to do the same thing again and again, sometimes with success or, in the case of Maryland, I believe, today some would say failure, in the Website. That alone was billions of dollars of unreasonable, unnecessary, redundant in the planning. For the States to all come together and use a common platform and common software was common sense. To divide it into contracts in which each State may or may not have chosen the same good vendor or, in some cases, the same bad vendor that the Affordable Health Care Act federally used is self-evident today.

Let's get passed the petty arguing about who voted for it or against it, whether we voted to repeal it or change it. Republicans and Democratic members are in fact, today, regularly talking about necessary change. I know the 7 million figure is big as of yesterday, and I know, as a Republican, I am told to say that very clearly that figure represents a great many people who lost their plans and, in fact, simply picked up and got the 7 million. Mr. Lee will undoubtedly, quite frankly, have to tell us that because California mandated to get onto the exchange, that you get off of programs that was necessary and deliberate cancellation of all kinds of programs in California because vendors had to choose whether to keep their old program or participate in the exchange. I am not holding anyone accountable; it probably seemed like a good idea at the time.

But the fact is we have not driven down the cost of health care to the individual except when the taxpayer picks up the tab.

So all of us today should begin looking not just at mistakes like thirty-some different Websites all paid for with Federal dollars, all essentially asking many of the same vendors to simply duplicate the software, but bill us twice, three times, four times for reinventing it. But we also should look at the question of, since we have not succeeded in the past in driving down the cost of health care through CMS's efforts, but, rather, repeatedly have simply said we will pay less and cost-shift as the Affordable Health Care Act is implemented and more and more people are under a federally subsidized program, where do we cost-shift to? We are running out of people we can cost-shift to, which means, by definition, everything we do will be something we have to pay for.

Mr. Chairman, this was long and I apologize for going over, but I, like you, are passionate about efficiency; and not just the Affordable Health Care Act, but all the Federal spending has to really be looked at.

Ms. Speier, I received your letter. I have taken note of the fact that corruption by vendors using Federal dollars is rampant and I believe that we do need to go after it, and I look forward to holding a hearing in which we look at both sides, vendors who sought to enrich themselves by getting more than they deserved and Government oversight agencies that let it happen until it piled up to hundreds of millions of dollars.

Mr. Cartwright, I want to thank you for something you did that you may have forgotten. You voted for FITARA. You voted on a bipartisan basis for a major change in how we procure IT. And the Senate, Senator Udall has a companion bill. When that becomes passed, we will become more efficient as a result of our oversight and legislation created on a bipartisan basis in this committee.

So I know we started off on a partisan basis. Hopefully, we can switch the tone to realizing that we are all living with increasing health care costs, and whether we voted for affordable care or not, we have a major role to try to drive down the future increases in health care if we are going to, in fact, be competitive around the world in commerce.

So I thank you.

Mr. Chairman, I thank you for your indulgence. Yield back.

Mr. LANKFORD. Thank you

I now recognize the ranking member of the full committee, Mr. Cummings, for his opening statement. Also, if you would please take time to introduce Mr. Lee of California, as well. I am sorry, of Maryland. Sorry, you are a representative from Maryland. Apologize.

Mr. CUMMINGS. You just moved me clear across the Country.

Mr. LANKFORD. I know. That is quite a shift. Sorry. I just shifted your time zones. I apologize.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Today is April the 3rd, just three days after the deadline for Americans to sign up for health insurance under the Affordable Health Care Act. A lot has happened in the past six months since the Federal and State exchanges opened for business. It has not al-

ways been pretty, but we should take a moment to reflect on what we have accomplished.

More than 7 million residents of our States have signed up for affordable health care. Millions of people who could not afford health insurance and were one accident or illness away from financial ruin now have health insurance. This is very significant. This is something that we all should be proud of.

And that is not all. We hear talk about what it didn't do, but under the Affordable Health Care Act insurance companies are no longer allowed to discriminate against people with cancer, diabetes, or other preexisting conditions. They are no longer allowed to discriminate against women. That is happening now. Millions of our residents receive free preventative care so they can stay well. We all know that it is cheaper to keep somebody well than to treat them when they are sick, if you want to talk about driving down the cost of health care. Millions of kids can stay on their parents' plan until they are 26, and billions of dollars in rebate checks have been sent to consumers across the Country. That has happened and it is happening now.

Ladies and gentlemen, put simply, the Affordable Health Care Act saves lives and it prevents people, from going through pain, and it allows people to live longer, like the gentleman who is probably watching us right now with colon cancer, knowing that he has a way to be treated and he will be able to walk his daughter down the aisle; or the person who just wants to survive long enough to see their child graduate from high school. That is what the Affordable Health Care Act is all about.

Sometimes I think we get so caught up in the problems that we are going through that we forget the big picture. Emerson said it best, he said do not be pushed around by your fears and your problems; be led by your hopes and your dreams. That is what this is all about, hopes and dreams.

So to the witnesses here today and to the State and Federal employees who are working tirelessly to implement the law, I want to say thank you. I look at Dr. Sharfstein of Maryland, the head of our health department. This is a man who has given his blood, his sweat, and his tears trying to make life better for people when he was the commissioner in Baltimore, and now with our State. And I can probably say that if I knew all the people there, I know that you all are doing the same thing. And you don't do this for the money; you do it because it feeds your souls. You do it because you want to make a difference. You do it because you want to affect generations yet unborn. And that is what we are all about, we should be about, making a difference so that people can live the best lives that they can.

The road we took to get here today was rocky for the Federal Government. It has also been challenging for some States, including my home State of Maryland. I cannot fully express how frustrated I was with the troubled rollout of the Maryland Health Connection. In my State, as in many of yours, people have a desperate need for quality, affordable health care. We needed the system to work. Let me say it again, we needed the system to work. Lives depended upon it. And when it did not, unnecessary obstacles were put in the way, which is completely unacceptable.

Now, let me say this. Sometimes you have contractors that advertise more than they can produce, so they sell you a bill of goods. Maybe those are the folks that we need to be looking at. But let's be clear. This is not just about a Website. It is not just about a Website. This is about making a difference for people so that they can be the best that they can be and be all that God meant for them to be.

The answer to the problems is not to decimate the Affordable Health Care Act. The solution is not to eliminate health care for millions of people, to gut the funding for the ACA, or to return to the days when insurance companies could discriminate against us based on our medical conditions.

I have said it before and I will say it again, we are better than that, to let insurance companies do that to us. The remedy certainly is not to try to scare people away from enrolling in health care they have a right to under the law. When you scare them away from enrolling, you have scared them away from having health care, from having insurance for being able to take care of their child when the child gets sick or prevent the child from getting sick. We are better than that.

Unfortunately, our Republican friends have voted more than 50 times to repeal, de-fund, and undermine the Affordable Health Care Act. And my friend Mr. Issa, the chairman of the committee, I agree with him, we need to move not to common ground, but to higher ground, what this Nation is all about. Higher ground, where we come together to try to figure out what is wrong and correct it and move forward.

So when history is written, when that man is able to walk down that aisle with his daughter, when that mother is able to see her child graduate from college, when that person lives long enough to see their first grandchild born, they are not going to be worried about whether a Website failed. They are not even going to be talking about that. They may not even know that it was the Affordable Health Care Act that saved them and gave them a life. All that will matter to them is they had an opportunity to live and live in dignity and have a moment of happiness.

So I am hoping that, as we move forward, since this is the law, by the way, that we move forward to make the law better, and not try to destroy it. And the only reason I mention these past efforts with regard to the numerous hearings is because I have not seen in these hearings one effort to improve the law, not one. If we could move to that, then we could move to higher ground.

With that, I yield back.

Mr. LANKFORD. Members will have seven days to submit opening statements for the record.

I would like to recognize our panel.

Mr. Cummings, would you like to introduce your guest from Maryland, as well?

Mr. CUMMINGS. Yes.

Dr. Sharfstein is the head of our health department in Maryland. As I said before, he has also served—by the way, he was a staff member on this committee, Mr. Chairman, some years back. Then he came to Baltimore and he was our commissioner of health there, where he brought all kinds of innovative projects to Baltimore, and

now he is head of our health department for the State of Maryland; and I am very pleased to have him.

Mr. LANKFORD. Ms. Speier, would you like to introduce anyone?

Ms. SPEIER. I am delighted to introduce Mr. Peter Lee, who is the Executive Director of Covered California, who has had a storied career in health care both in the private and public sector, and formerly was the Deputy Director of the Center for Medicare and Medicaid Innovation at CMS, among many other places.

Welcome. We are very glad you are here.

Mr. LANKFORD. Thank you.

Mr. Matsuda, you definitely have the longest time zone change here of any of the folks that are here. We are glad you are here. He is the Interim Executive Director of the Hawaii Health Insurance Exchange.

Ms. Jean Yang is the Executive Director of the Massachusetts Health Insurance Exchange.

Mr. Scott Leitz is the Interim Chief Executive Officer of the Minnesota Health Insurance Exchange.

Mr. Greg Van Pelt is the Advisor to the Governor of the Oregon Health Insurance Exchange.

Pursuant to committee rules, all witnesses are sworn in before they testify, so if you would please stand and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you, God?

[Witnesses respond in the affirmative.]

Mr. LANKFORD. Thank you. You may be seated.

Let the record reflect all the witnesses answered in the affirmative.

In order to allow time for discussion, I ask you to be able to limit your testimony to five minutes. Your entire written statement, which all of you have submitted, will be a part of the permanent record as well.

Mr. Matsuda, you are batting off the beginning here, to do a little spring baseball conversation there. So you are first up. If you press the talk button, we would be glad to be able to receive your testimony for five minutes.

WITNESS STATEMENTS

STATEMENT OF TOM MATSUDA

Mr. MATSUDA. Thank you, Chairman, ranking members, and members of the subcommittees. My name is Tom Matsuda, Interim Executive Director of the Hawaii Health Connector, speaking on behalf of the Connector and its board of directors.

Hawaii has long been a leader to ensure that our residents have access to quality, affordable health insurance. In 1974 Hawaii enacted a groundbreaking State law, the Hawaii Prepaid Health Care Act. This law requires that most employers in Hawaii provide health care coverage to employees who work more than 20 hours per week for at least four consecutive weeks.

Hawaii's Prepaid Health Care Act requirements are generally stricter than those of the Federal Affordable Health Care Act. As a result, Hawaii has a low uninsured rate, estimated at about 8

percent, or 100,000 individuals. Because the State law is so strongly supported by the people of Hawaii, the Aloha State authorized the establishment of a State-based marketplace to harmonize the ACA with the Hawaii Prepaid Health Care Act.

My written testimony provides detail about the Connector and I would like to focus on some specific issues.

First of all, enrollment. As of March 31st, 2014, we have 7,596 individuals enrolled in commercial plans through the individual marketplace, 265 people enrolled through the SHOP small employer marketplace, and 24,641 completed applications in our system.

The Connector does not handle Medicaid eligibility or enrollment for the Medicaid population; that is handled through the Department of Human Services, or DHS. DHS had over 28,800 Medicaid enrollments from last October through February this year, for a total of over 36,661 enrollments across the entire Hawaii marketplace.

We launched our online marketplace on October 15th and accepted initial application forms between October 1st and 15th. The system has been operating since then, but it was very difficult to use at first. As of now, we have made significant improvements. The system is better today than it was back in October. Our system is working from end-to-end, but more improvements can be made.

Sustainability. As a State-based marketplace, we must be self-sustaining by January 1st, 2015. Last year, the Connector board approved a 2 percent premium assessment for plans sold on the Connector. Our board is now engaged in a sustainability planning process. The key is to reduce operating expenses while supplementing enrollment, especially in the SHOP exchange. The Federal and State decisions to give small employers the option to remain with their existing insurance plans through 2016 have reduced the volume of participants in SHOP.

Hawaii has received four Federal grant awards. While Hawaii is a small State, we are subject to the same Federal requirements as all other States to establish the infrastructure to operate these State-based marketplaces. The establishment costs will be comparable from State to State to ensure that the structural components of the marketplace are compliant and secure. Our small population and low uninsured rate mean that Hawaii has a smaller market to support our operating costs. As of December 31st, 2013, the Connector has spent about $57 million of the total $204 million in Federal grant monies awarded to us and we have an operating system.

For our priorities going forward, we have roughly 11,000 incomplete applications. These individuals' enrollment is not yet complete. We have increased staff to complete this process. We are also working on extending our outreach into island communities that are underserved to help educate these populations about the services available to them.

On behalf of the Hawaii Health Connector, I appreciate the opportunity to discuss these issues with you today. We have much left to accomplish, but we believe in the mission of the Connector and are fully committed to contributing our part in Hawaii's long

history of providing access to affordable, quality health care coverage to our residents. Thank you.

[Prepared statement of Mr. Matsuda follows:]

Update on the Hawai'i Health Connector

Statement of

Tom Matsuda

Interim Executive Director

House Committee on Oversight & Government Reform
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs and
Subcommittee on Energy Policy, Health Care and Entitlements

Hearing: Examining ObamaCare's Problem-Filled State Exchanges

April 3, 2014

P.O. Box 1170 Honolulu, HI 96807 | www.hawaiihealthconnector.com | Tel: (808) 312-4400

Introduction

Chairman Issa, Ranking Member Cummings, and Members of the Committee and Subcommittees,

My name is Tom Matsuda, Interim Executive Director of the Hawai'i Health Connector (the "Connector"), speaking on behalf of the Connector and its Board of Directors.

The Connector, established as a non-profit organization, is an online health insurance marketplace, created to help individuals and small businesses take advantage of the health insurance choices available to them. Our mission is to help the people of Hawai'i live happier, healthier lives by making sure that health insurance is not only easier to purchase, but also, easier to understand.

Background

Hawai'i has long been a leader, ensuring that our residents have access to quality, affordable health insurance. In 1974, Hawai'i enacted the Hawai'i Prepaid Health Care Act, which generally requires that most employers in Hawai'i provide health care coverage to employees who work more than twenty hours per week for at least four consecutive weeks. As a result of Hawai'i Prepaid Health Care Act requirements, which are generally stricter than those of the Affordable Care Act (ACA), Hawai'i has a lower uninsured rate than all but one other state (Massachusetts), estimated at about 8%[1]. The Hawai'i Prepaid Health Care Act has also resulted in benefits being offered that are more generous than benefits available[2] to employees in other states' small employer markets[3]. Finally, Hawai'i Prepaid established an affordability test for employer-based coverage that is stricter than that required by the ACA. The State's priority has been to establish a State-based Marketplace and harmonize the Hawai'i Prepaid Health Care Act requirements with those of the Affordable Care Act.

Because of the Hawai'i Prepaid Health Care Act, the Aloha State embraced the option to build our own Exchange in order to remain directly involved with protecting and enforcing the requirements of this groundbreaking state law. In 2011, the State Legislature passed Act 205[4], which created the Hawai'i Health Connector to implement Section 1311 of the ACA. On June 27, 2012, Governor Abercrombie became the first Governor to submit a letter of intent to establish a State-based Marketplace.

I came to the Hawai'i Health Connector as interim executive director on December 9, 2013. Since starting in this new role, I have established several priorities: increasing enrollment of consumers who want to obtain health insurance plans, assisting the board of directors with developing a sustainability plan for future years, improving the IT systems in the Connector's portion of the exchange to enable faster, more user-friendly applications and enrollments and contributing to the State's efforts to preserve the protections of the Hawai'i Prepaid Health Care

[1] See Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Total Population, available at: http://kff.org/other/state-indicator/total-population/

[2] See Oliver Wyman Analysis, enclosed.

[3] Defined in Hawai'i as employers with fifty or fewer employees. Hawaii Revised Statutes §431:2-201.5.

[4] Act 205, 2011 Legislative Session, is codified in Hawaii Revised Statutes §435H.

Act for employees of small employers in Hawai'i. Prior to taking on this role, I served as the Affordable Care Act implementation manager for the Governor's Office.

I welcome the opportunity to share more information with you about the Connector and answer any questions you have. To hopefully address some of your questions, I would like to take this opportunity to address four issues: 1) enrollment through the Connector, including factors that have uniquely impacted enrollment, 2) ensuring the Connector is self-sustaining in 2015, 3) expenditures in support of exchange implementation, and 4) our priorities going forward.

Enrollment

As of Sunday, March 30:

- 7,242 individuals have enrolled in commercial health insurance through the Connector (Individual and SHOP);
- 281 employers are participating in the SHOP Marketplace; and
- In total, 23,692 applications have been completed.

If one views the Hawai'i State-Based Marketplace as a combined effort between the state's Medicaid Program and the Connector, from October 2013 to February 2014, the state Medicaid program has processed, approved and enrolled over 28,800 Medicaid eligible people. The Connector has processed 7,242 QHP enrollments for individuals with and without financial assistance and SHOP Employees as of March 30, 2014. The combined total of enrollments in our State-Based Marketplace is over 36,042.

Unfortunately, we face some significant issues which delay enrollment as well. For example, there is currently a backlog of roughly 11,000 financial assistance applications within the Individual Marketplace that have been processed by our state Medicaid program and must be evaluated by the Connector for other premium assistance eligibility. We are working to make the necessary eligibility determinations in order to process the applications that remain "in queue" at this time. We have more than tripled the number of call center representatives and are making as many as 1,000 outbound calls each day to collect information from consumers so we can process their applications.

You can find all of this information – as well as data on the total number of calls received by our customer support center, the number of in-person assisters and certified application counselors, and the number of unique visits to our website - at www.HawaiiHealthConnector.com. We update these figures every week so that the public can see our progress and hold us accountable.

Regarding the demographics of enrollees, enrollment is split roughly evenly across males and females. While we understand there is interest in the number of our enrollees who were previously uninsured, this data is not captured in the applications and, therefore, is not available to us.

Prepaid Health Care Act: Impact on the State's Insurance Market

The Connector's total enrollment, to date, is low – especially as compared to other State-based Marketplaces. I believe there are several reasons for this. The Hawai'i health insurance marketplace is unique, as noted above. We have a small total population of roughly1.4 million

residents, with only 8% uninsured, or about 100,000 lives. Hawai'i's Prepaid Health Care Act has existed for 40 years and is largely responsible for the low number of uninsured individuals.

In addition to requiring most employers to offer coverage to employees who work more than twenty hours per week, the Hawai'i Prepaid Health Care Act also prescribes certain other requirements that are generally more stringent than the ACA. For example, under the Hawai'i Prepaid Health Care Act, employees can be required to contribute up to the lesser of 50% of plan cost or 1.5% of income; for most employees, contributions will almost always be capped at 1.5% of income. Therefore, anyone whose employer complies with the Hawai'i Prepaid Health Care Act is extremely unlikely to qualify for tax credits in the Connector. Insurance benefits offered under the Hawai'i Prepaid Health Care Act are often more generous than benefits typically available to individuals in other states.

Consequently, Hawai'i's priority has been to harmonize Hawai'i Prepaid Health Care Act requirements with the ACA requirements. The ACA included a specific carve out for the Hawai'i Prepaid Health Care Act so that the state law's more generous requirements would be maintained. We are proud of our State's history with respect to ensuring coverage for the vast majority of our residents. However, because Hawai'i's Prepaid Health Care Act has been well established for 40 years and virtually all small employers that could use the SHOP Marketplace already purchase insurance for their employees, generating SHOP enrollments is a challenge in Hawai'i. In the Individual Marketplace, excluding the uninsured eligible for Medicaid, there are not enough likely participants to enroll at a volume necessary to sustain the Connector's operations unless we have substantial SHOP enrollments as well.

Hawai'i Demographics and Geography

Also impacting the insurance market is Hawai'i's diverse population and geography. Out of a population of roughly 1.4 million, about 10% identify as Native Hawaiian or other Pacific Islanders[5]. There are at least 45 different Asian and Pacific Island languages spoken in the state[6], with one quarter of our population speaking a language other than English at home and just over half of the population is able to speak English "very well."[7] Hawai'i also has a unique geography, with our population spanning across seven major islands. The combination of our cultural, linguistic, and geographic diversity has posed challenges to engaging in effective outreach and education about the Marketplace. We are continuing to address this challenge and are hopeful that improvements in our strategies will facilitate greater enrollment.

October 1 Delay

The Connector experienced some well-known operational challenges last fall. First, the Connector made a decision to delay the launch of the online marketplace for two weeks. The Connector, as with all of the other Marketplaces, anticipated opening for online business on October 1, 2013. On the eve of opening, it was brought to the Connector's attention that, despite all of the testing held to date, the portal would not perform as expected. Erring on the side of

[5] According to the 2010 Census; Hawaii data available at: http://quickfacts.census.gov/qfd/states/15000.html.
[6] *See* Detailed Language Spoken at Home and Ability to Speak English for the Population 5 Years and Older by States: 2006-2008 (ACS), available at: http://www.census.gov/hhes/socdemo/language/.
[7] *See* U.S. Census, Language Use in the United States: 2011, available at: http://www.census.gov/prod/2013pubs/acs-22.pdf

caution, it was decided to delay the launch of the Connector's portal until October 15, 2013. Interested consumers were given the opportunity to submit a secure online initial application form between October 1 and October 15.

Since October 15, 2013, consumers have been able to fill out and submit online applications, and review, select and enroll in plans. The system is under continuous improvement in order to meet the demands of the public. As a result, the functionality and usability of the system is considerably better today than it was back in October, but much work remains to be done. The Connector is considered to be a "smart application," because of the many components that need to interoperate seamlessly behind the Connector's portal. The Connector's system must be able to interact not only with the consumer, but receive information from our state Medicaid agency, and interact with the State Data Services Hub through which information is transmitted and obtained from the Federal Data Services Hub. The coordination between all entities involved is complex.

Prior to launch on October 15, 2013, the Connector satisfied all security-related requirements imposed by the Center for Medicare and Medicaid Services (CMS) and the Internal Revenue Service (IRS) that were necessary to receive Authority to Connect to the Federal Data Services Hub via the State Data Services Hub. The Connector received written Authority to Connect from the IRS on September 27, 2013, fulfilling the last requirement to connect to the Federal Hub via the State Hub.

Expected versus Actual Enrollment
Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") was engaged by the Hawai'i Department of Commerce and Consumer Affairs to assist them in conducting planning tasks related to the development of the Connector (analysis enclosed). The analysis was done under the assumption that the Connector would include the Individual Marketplace and SHOP Marketplace. Oliver Wyman concluded that, based on their review, there were approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) with incomes that would make them eligible for subsidies and would therefore be primary candidates for individual coverage through the Connector. In addition, Oliver Wyman estimates that there were approximately 151,000 individuals covered through small employers that would be eligible to enroll through the Connector. As noted below, in the context of our sustainability planning, there were several Federal and State policies implemented that have limited the Connector's ability to draw a significant number of these employers into the Marketplace.

Uninsured Rate
Prior to implementation of the Marketplace, Oliver Wyman estimated that approximately 52.6% of residents are covered by employer sponsored insurance (ESI) in either the small employer, fully insured large group or self-insured markets. Oliver Wyman also estimated that 17.1% were covered by Medicaid or other low-income assistance, and 7.6% were uninsured (of which roughly half are eligible for Medicaid). According to Oliver Wyman's report, their research showed that a large number (not quantified) of the uninsured population have incomes over 400% of the Federal poverty level (FPL), which would disqualify them for tax credits in the Connector.

Sustainability
According to the ACA, the Connector must be self-sustaining as of January 1, 2015. Under current CMS guidance, no federal funds may be used for Connector maintenance and operations after 2014. Last year, the Connector Board approved an assessment of 2% of the premiums for plans sold on the individual portal against the issuers beginning January 1, 2014, and an assessment of 2% of the premiums for plans sold on the SHOP portal against the issuers beginning July 1, 2014.

The Connector Board of Directors is engaged in a sustainability planning process to include options for reducing operating expenses and increasing revenue. As I outlined in my memorandum to the Board of Directors[8] on February 10, 2014 (enclosed), the key concept in our proposal is to supplement enrollment in the Individual Marketplace by examining the revenue opportunity provided by the Connector's SHOP while continuing to harmonize ACA implementation with the Hawai'i Prepaid Health Care Act.

The key to our sustainability has always been small employer enrollments in our SHOP. Due to the existence of Hawai'i Prepaid Health Care Act and the small number of health insurers in the state, there is little need for the average small business to use SHOP. The ACA small business tax credit is a real incentive, but few businesses may decide that the credit provides enough incentive to leave familiar insurance plans and processes they have used for many years. Also, the federal and state decisions to give SHOP employers the option to remain with their existing insurance plans through 2016 has reduced the volume of potential customers. The State has a pending request to extend this option through 2017. If granted, SHOP enrollment volume will be limited for an additional year beyond existing policy.

On the other hand, SHOP enrollment potential could increase more in 2016 and 2017 due to planned ACA enhancements to SHOP. The ACA increases the definition of small business for SHOP from 50 to 100 employees in 2016 and allows the state to permit large employers to enroll through SHOP starting in 2017. These expansions could increase the number of enrollments. Conversely, potential choices by the State, such as 1:1 age rating (i.e., community rating) or direct enrollment, could reduce the number of enrollments in SHOP. Therefore, the true revenue potential of SHOP isn't knowable yet. A sound sustainability plan should take these potential impacts on enrollment into account through alternative budget scenarios.

Innovation waivers are available under the ACA starting in 2017. Since it appears that short-term sustainability for the Connector will be challenging, and because Hawai'i's Prepaid Health Care Act already provides many benefits that are more generous than the ACA, the state innovation waiver provides a good opportunity to find a long-term solution that suits Hawai'i's unique health insurance market. This is an important factor in our board sustainability planning process.

Budget Expenditures
The Connector is currently funded by federal grants specifically set aside for the establishment of the health insurance exchanges, now known as health insurance marketplaces. All funds must be

[8] http://www.hawaiihealthconnector.com/wp-content/uploads/2013/09/Memo-to-BOD_Sustainability-Planning_021014.pdf

spent in accordance with the allocations outlined in each grant application. Funds not expended and/or not expended in accordance with the grant allocations would need to be retained by the Federal government. Hawai'i has received four Federal grant awards: one Planning Grant, two Level One Establishment Grants, and one Level Two Establishment Grant. While Hawai'i is a small state, we are subject to the same Federal requirements as all other states for establishing the necessary infrastructure to implement and operate a State-based Marketplace. We expect variation across these states in spending on personnel and other discretionary measures, but the underlying establishment costs will be comparable from state to state to ensure that the structural components of the Marketplace are compliant and secure. Our small size means that Hawai'i has fewer individuals to spread these costs across.

On September 30, 2010, the Hawai'i Department of Commerce and Consumer Affairs (DCCA) was awarded $1,000,000 for the following activities: conduct background research on the issues related to developing an Exchange; involve stakeholders in the planning process; examine integration of the Exchange with existing programs; assess resource capabilities; consider the appropriate governance mechanism; determine appropriate accounting and reporting guidelines; determine appropriate technical infrastructure; research business operations including implementation issues; examine regulatory and policy aspects; and appoint a task force to discuss the issues concerning implementation of an Exchange and receive and process comments from the public.

On November 29, 2011, the DCCA was awarded a Level One Establishment Grant in the amount of $14,440,144, which was later reassigned to the Connector; on August 23, 2012, the Connector was awarded a second Level One Establishment Grant in the amount of $61,815,492. The first Level One grant (Level One-1) in the amount of $14.4 million dollar was initially awarded to the Insurance Division of the Department of Commerce and Consumer Affairs (DCCA) on or about November 17, 2011, for a term of one year. At this time, the interim board under Act 205 had not been appointed and the Executive Director had not yet been hired. The Level One-1 grant was subsequently reassigned to the Connector on March 11, 2013, with an amount of approximately $10.2 million remaining in the grant. An extension was obtained to November 17, 2013. This grant has been completed, subject to final processing.

The funds from the Level One-1 grant were utilized to retain the IT Consultant (Public Consulting Group (PCG)) to establish the project management office, establish the Connector offices, hire staff and meet criteria as required for a mandatory design review with the Center for Consumer Information and Insurance Oversight (CCIIO), which oversees the Marketplaces and grants. As of the end of June 2013, approximately $8.5 million had been expended to establish the Connector and to begin the IT process.

The second Level One grant (Level One-2) was applied for by the Connector in June 2012. The Federal government awarded the Connector $61.8 million on August 23, 2012. This is the primary funding source for the Connector to build its IT system that would become the health insurance marketplace for Hawai'i. A large portion of the funds were "restricted" until the Connector was able to release specific information pertaining to its vendors, to CCIIO. The primary vendors supported by this grant are: 1) CGI Technologies (IT Vendor); 2) Turning Point (Independent Verification and Validation Services contractor); 3) PCG (IT Consultant/Project

Manager); 4) Mansha Consulting (Integrated Project Management and IT Services); 5) MVNP (communications); and other vendors. This funding also provided support for the operational expenses such as establishing the Hi'i Ola public education and outreach program and continued operation of the Connector. The funds in the Level One-2 were set to expire on August 22, 2013; however, the Connector has received an extension to August 21, 2014.

On April 8, 2013, the Connector was awarded a Level Two Establishment Grant in the amount of $128,086,634. The funds are set to expire on April 7, 2014; the Connector has requested an extension for the funds. Hawai'i's Level Two Establishment Grant was requested and awarded to allow the Connector to hire staff, develop and execute contracts, and continue to develop a strong infrastructure to assure performance of activities related to the creation and on-going operation of the Marketplace. In addition, the requested funding has been and will be used toward building a robust outreach and stakeholder engagement strategy, such as implementation of the in-person assister program, a comprehensive and coordinated training program to reach a wide audience, the development and implementation of the Call Center, and a variety of other outreach activities.

Budget Allocations and Current Spending Levels
As of December 31, 2013, the Connector has spent about 28% of the total amount of Federal grant monies awarded to us. The majority of Federal funds spent to date have been for our vendor contracts. Additional monies have been spent on salary and wages, benefits, and other program development activities. Additional details on the amount of money that has been spent and how can be found in our financial overview (enclosed)[9]. The Connector's most significant contract is with CGI for the development and maintenance of the online health exchange and hosting environments.

The Connector has executed two contracts dedicated to marketing and advertising services, with MVNP and Oahu Publications Inc. Spending on these contracts is capped at roughly $3.2 million; as of the end of last year, roughly 86% of those dedicated funds had been expended. The MVNP contract expired at the end of 2013; the Oahu Publication contract is scheduled to expire at the end of 2014.

The Connector also has contracts with: a law firm for legal services; the Department of Human Services (DHS), our state Medicaid agency, for system integration and connectivity between DHS' Medicaid system, the State Data Services Hub and the Connector; Mansha Consulting, for Integrated Project Management and IT services; Maximus, for Contact Center operations; Turning Point for independent verification and validation testing and documentation; and Public Consulting Group (PCG) for PMO services and IT and business consulting, and information system development.

Priorities going forward
In addition to finalizing a workable sustainability plan for the Connector, we see several short-term challenges that we are working to address.
Application Backlog

[9] Also available at: http://www.hawaiihealthconnector.com/wp-content/uploads/2013/09/HHC-Q2FY14-Quarter-Ended-12.31.13-Financial-Overview-2.21.14.pdf

As of March 30, 2014, there were roughly 11,000 financial assistance applications in our system that had not yet been processed and, in turn, these individuals have not yet been enrolled in coverage. Under the current process, all consumers who want to be considered for financial assistance are sent from the Connector to DHS for a Medicaid eligibility determination. Some applications that have been returned to the Connector because the individuals did not qualify for Medicaid need additional information to allow the Connector to determine eligibility for premium assistance. To address this issue, the Connector increased staff in our contact center to conduct additional outreach to applicants and get that needed information. We have also indicated that if individuals submitted an application by March 31, we will work with them to get coverage, even if they had not yet picked a plan.

Outreach

We understand that community education and outreach efforts and public awareness need to be improved for the next open enrollment period. For these reasons, the Connector issued two requests for proposals last week seeking contractors to perform marketing services and public relations. Looking forward to the rest of 2014 and beyond, the Connector hopes to partner with community based groups to extend its outreach into the communities that are underserved and help to educate these populations about the services available to them, including health insurance plans, premium assistance, the Affordable Care Act, and Medicaid (in coordination with the Department of Human Services (DHS)).

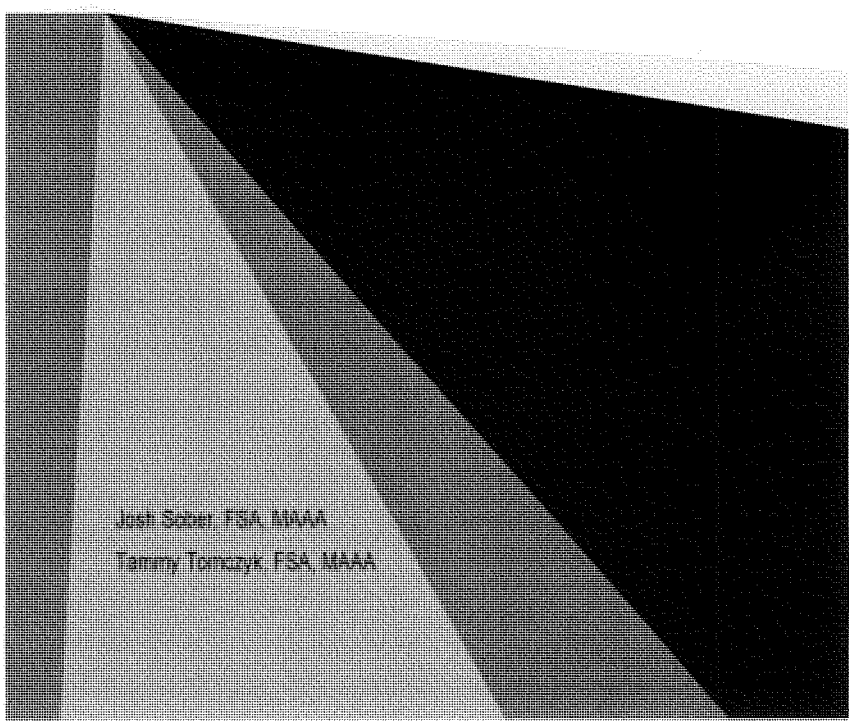
Conclusion

On behalf of the Hawai'i Health Connector, I appreciate the opportunity to discuss these issues with you today. We have much left to accomplish, but we believe in the mission of the Connector and are fully committed to contributing our part in Hawai'i's long history of providing access to affordable, quality health coverage to our residents.

OLIVER WYMAN

CURRENT STATUS OF INSURANCE COVERAGE IN THE STATE OF HAWAI'I

HAWAI'I DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS, INSURANCE DIVISION



MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

The Affordable Care Act of 2010 (ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (Exchanges). Under the ACA, each state may elect to set up an Exchange that will create a new marketplace for heath insurance. Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Hawai'i Department of Commerce and Consumer Affairs to assist them in conducting planning tasks related to the development of Hawai'i's Connector (the Connector). The Connector would include the individual Exchange and Small Business Health Options Program (SHOP) Exchange. One of our primary tasks of this engagement was to prepare background research of Hawai'i's current population and health insurance marketplace. Much of what we present in this report will serve as a basis for future phases of this planning project.

For this report, we have relied on numerous data sources both as a basis for estimates as well as to validate our conclusions. We based much of the demographic analysis on data from the American Community Survey (ACS). The ACS is conducted by the United States (US) Census Bureau and participation in it is required by law for those who are selected. We felt it important to rely on a primary data source to ensure consistency of estimates, and we chose the ACS because, among other reasons, the US Census Bureau attempts to correct a well documented phenomenon of population surveys called "the Medicaid undercount." The Medicaid undercount manifests itself when Medicaid enrollment estimates from survey data are substantially lower than actual state enrollment reports. For these analyses, we have relied on estimates from calendar year 2010. In addition, we relied on publicly available financial statements from insurer participants in Hawai'i's insurance market, as well as on information from insurance carriers' websites.

Based on the ACS data and information from the Med-QUEST Division in the Department of Human Services, we estimate that Hawai'i's residents are covered by the following modes of insurance. (Please note that the estimates of persons and standard deviations are in 1,000's.)

Table 1.1
Coverage Summaries (in 1,000's)

	Hawai'i			Nation		
Coverage	Persons	Distribution	Stand Dev +/-	Persons	Distribution	Stand Dev +/-
Employer (non-Medicare)	717	52.6%	4.7	148,868	48.2%	70.9
Employer (Medicare)	95	7.0%	1.3	13,668	4.4%	16.6
Military (Active)	93	6.8%	2.3	5,236	1.7%	17.5
Military (Retired)	1	0.1%	0.2	357	0.1%	3.3
Direct Purchase	44	3.2%	1.6	16,616	5.4%	34.0
Medicare	77	5.6%	1.4	22,455	7.3%	20.0
Medicaid	193	14.2%	3.5	43,541	14.1%	49.9
Dual	39	2.9%	1.4	9,815	3.2%	19.2
No Coverage	104	7.6%	2.2	48,257	15.6%	48.1
Total	1,363	100.0%		308,813	100.0%	

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, we estimate that approximately 52.6% of residents are covered by employer sponsored insurance (ESI) in either the small group, fully insured large group or self insured markets. We also estimate that 17.1% are covered by Medicaid or other low-income assistance, and 7.6% are uninsured. Identifying characteristics that might indicate a person's tendency to change insurance modes was one of our chief goals in evaluating Hawai'i's population. In subsequent sections, we present some specific elements of the ACA that helped guide our review of those characteristics. Although we present summaries of Hawai'i's population composition, we show results of our migration models in a forthcoming research paper.

The majority of Hawai'i's residents are insured by ESI. However, Hawai'i's Prepaid Health Care Act and the State's large military presence make Hawai'i unique from other states. In particular, the Prepaid Health Care Act prescribes coverage levels for employers as well as contribution requirements. As a consequence, Hawai'i not only has a lower uninsured rate than other states, but its benefits are more generous. Because of the efficacy of the Prepaid Health Care Act, we suspect that the ACA's provisions will not induce Hawai'i's employers to drop employee coverage at the rate we anticipate for employers in other states.

Although the State has few residents covered by individual health insurance, this segment of the population will be significantly affected by provisions of the ACA. These policy owners are likely to see changes in premium rates, but more importantly, they will face a new domain of incentives as well as a new venue for purchasing coverage.

For its low-income population, Hawai'i also has a robust managed Medicaid program. In addition to people qualifying under TANF or CHIP, the State's Med-QUEST program provides coverage to low-income, childless adults through its QUEST-Ace and QUEST-Net programs.

With the Prepaid Health Care Act, the military presence, and expanded Medicaid programs, the uninsured population in Hawai'i is 7.6%, which is lower than the national average. The ACA provides incentives in the form of tax penalties and credits for these individuals to enter the insurance market. However, the data supporting this background research showed that a large number of the uninsured population have incomes over 400% of the Federal poverty level (FPL), which would disqualify them for tax credits in the Connector. There are no clear indications of why these people do not obtain coverage, so it is difficult to assess their likelihood of obtaining coverage once it becomes a requirement.

The basic health program (BHP) is expected to support provisions of the ACA and stabilize coverage for the low-income population. There is evidence that a significant portion of the population under 200% of FPL (non-Medicaid and Medicaid eligible) will gain or lose their Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. If Hawai'i were to contract with a plan under the BHP, the Federal government would provide the State 95% of the premium tax credits and cost-sharing subsidies that would have been provided for those individuals had they been enrolled with individual coverage in the Connector. Although members could be required to pay a premium, there would also be some level of cost-sharing subsidization for BHP participants, based on their income.

The strength and viability of Hawai'i's Connector will depend directly on the number of people that use it. In this background research, we have only identified residents that could be affected by the ACA's incentives; we have not considered the likely enrollment in the Connector. Based on our review, there are approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) with incomes that would make them eligible for subsidies and would therefore be primary candidates for individual coverage through the Connector. In addition, there are currently approximately 151,000 individuals covered through small groups that would be eligible to enroll through the Connector. Although we do not expect that all of these residents would enroll in the Connector, our forthcoming analysis from Oliver Wyman's micro-simulation model will produce a more precise estimate. These estimates include individuals with income between 139% of FPL and 200% of FPL; so, many of these individuals would also be eligible for a BHP if the State were to employ it.

This background research precedes additional analysis that Oliver Wyman will provide to Hawai'i as part of this planning process. In this paper, we attempt to present a historical representation of Hawai'i's population; this background presentation includes no projections of either the population or the composition of the State's insurance market. Other papers in the series include a discussion of the State's essential health benefits package design, projections of the State's insurance market as produced by Oliver Wyman's proprietary microsimulation model, and projections of potential Basic Health Plan enrollment (under a scenario in which the

State elects to participate in such a program). The conclusions in this report will provide a basis for these further analyses.

2

Introduction

Under the Affordable Care Act (ACA), the Federal government provides funding assistance for the planning and establishment of the Exchanges. Each state may elect to set up Exchanges that will create a new marketplace for heath insurance. The Exchanges will offer consumers a choice of health plan options, oversee the pricing and certification of health plans offering coverage within the Exchanges, calculate premium subsidies and provide information to assist consumers in their purchasing decisions.

Oliver Wyman was engaged by the Hawai'i Department of Commerce and Consumer Affairs (DCCA) to assist them in conducting planning tasks related to the development of Hawai'i's Health Connector (the Connector), which includes the individual Exchange and Small Business Health Options Program (SHOP) Exchange. As one of our initial tasks, we conducted background research required to assess Hawai'i's current population and health insurance marketplace, as well as to prepare this report. This research serves multiple purposes. First, it will provide the DCCA and other key stakeholders and decision makers with a view of Hawai'i's market prior to the implementation of significant reforms. Second, it will serve as the basis for many of the inputs into our modeling, which will occur in a subsequent phase of our work.

In the following sections, we provide a general overview of Hawai'i's current market composition by payer type, including the uninsured. Next, we take a more detailed look at each of the key payer types in turn, examining distributions by various demographic, socioeconomic, and in some cases, geographic categories. For the commercial markets, we include information on current benefit offerings and associated premiums. We also present a summary of some of the rating factors and methodologies used by carriers currently offering coverage in Hawai'i's individual and small group markets. We also provide some initial, high-level indications of the effect that changes required under the ACA could have on rates in these markets in Hawai'i. Finally, we provide a primer on the Basic Health Program (BHP), an optional program that Hawai'i may elect to set up for individuals with incomes between 138% and 200% of the Federal Poverty Level (FPL).[1]

Oliver Wyman has prepared these projections exclusively for the DCCA, to assist the State of Hawai'i (the State) in planning and preparing for the establishment of the Connector. Consistent with Paragraph 24 of the General Conditions of the Contract for Professional Services, this report was prepared for the sole use by the State. All decisions in connection with the

[1] Although the ACA specifies an income threshold of 133% of FPL, it includes a 5% disregard, effectively making the threshold 138% of FPL

implementation or use of advice or recommendations contained in this report are the sole responsibility of the State. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report has been issued. These estimates were based on regulations issued by the United States Department of Health and Human Services (HHS), several of which are still in draft form. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available as of October 1, 2012, and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability. We have relied on a wide range of data for our analysis including but not limited to information received from commercial carriers offering coverage in the State and various State agencies. We have not independently audited these data, however we have reviewed it for reasonableness and asked clarifying questions where warranted.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding the ACA. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated within this report.

Lastly, the State understands that Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute, for legal advice. Accordingly, Oliver Wyman recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

There are no third party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

The information contained in this document and in any of the attachments is not intended by Oliver Wyman to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Data and Reliance

In preparing this report, we have reviewed numerous sources of information on participants in Hawai'i's health insurance marketplace. The information included reports from the Med-QUEST Division, the Department of Human Services (DHS), the Department of Labor and Industrial Relation (DLIR), Milliman (one of the consultants for the State), rating data provided to us from carriers in the State, presentations of Hawai'i's estimated uninsured population, reports from the Centers for Medicare and Medicaid Services (CMS), data from the US Census Bureau, the Medical Expenditure Panel Survey (MEPS), Dun and Bradstreet, annual statutory financial statements of insurers issuing policies in Hawai'i, and various other sources. As a simplified characterization of these data, we can best classify them as representing either Hawai'i's population or an insuring entity covering Hawai'i's residents and workers. In the sections below, we discuss our primary data sources for these two classifications of information.

Population Data

We relied on various data sources from the US Census Bureau in estimating both the overall size of the population in Hawai'i as well as in segmenting the market by characteristics such as type of insurance coverage, age, gender and income. Our primary source for these data was the American Community Survey (ACS).

As we have reviewed potential data sources for this and for similar projects, we felt it important that we have one primary data source as a starting point for our analysis. Had we instead relied on data from numerous independent sources as the basis for various aspects of our analysis, we would have faced potential inconsistencies in definitions, time periods and collection techniques among these various sources. As such, we found two primary data candidates for our analysis: the Current Population Survey (CPS) and the ACS. The CPS is conducted by the US Census Bureau and the Bureau of Labor Statistics. It includes interviews of 60,000 households and is primarily focused on reviewing employment levels. The ACS is also conducted by the US Census Bureau. It is sent to approximately 2.9 million housing units per year and gathers information that is only contained in the long form of the decennial census.

We selected the ACS data for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. ACS applies logical edits to the data to adjust for this 'Medicaid Undercount.'[2] Second, the ACS questionnaire includes the question: "Is this person CURRENTLY covered by any...health insurance or health

[2] *http://www.census.gov/hhes/www/hlthins/publications/coverage_edits_final.pdf*

coverage plans?"[3] (Emphasis is from the survey). In contrast, the CPS assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the forthcoming migration modeling, as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the ACS so, the response rate is quite high (i.e., 98% in 2009).[4] The high response rate both helps to ensure precision of the survey data and hopefully eliminates any potential bias in the Census Bureau's methodology. Fourth, and finally, the ACS includes measures that permit the calculation of standard errors from the sample. We may find these capabilities helpful once we begin developing assumption ranges for the model.

Although the ACS data possess many advantages, they also pose several challenges. We identify some of those challenges here. First, the ACS data are drawn from a small subset of Hawai'i's households. The US Census Bureau then assigns weights to each respondent so that they are intended to characterize the entire population. The data present a less reliable picture of the population as questions become more specific. For example, if we wish to review broad income ranges for Hawai'i's entire population, the ACS queried 13,615 individuals from whom we can assess those levels of income in 2010. We can be fairly certain that the income reported from those 13,615 individuals will be representative of the income for all of Hawai'i's 1,363,621 residents in that year. However, if we wish to examine the income for the privately employed, uninsured population between the ages of 18 and 30, we have only 198 respondents during that same year from which to draw our conclusions. If only a few of these respondents have incomes that are very different from the population they are intended to represent, our conclusions could be skewed. As our questions become more specific the data become less reliable.

Second, because of these credibility issues and because the US Census Bureau includes an allocation methodology for those questions that a respondent might not address in the questionnaire, the estimates will often differ from other credible data sources. For example, the following table shows several estimates of Hawai'i's uninsured population as a percent of the total in 2010.[5]

Table 3.1

Study / Survey	Uninsured
ACS	7.6%
Kaiser Permanente*	8.2%
Gallup Poll**	10.6%

*Hawaii's Uninsured Population Update, Lee, 2011

**http://www.gallup.com/poll/146579/texans-likely-uninsured-mass-residents-least.aspx

[3] *http://www.census.gov/acs/www/Downloads/questionnaires/2009/Quest09.pdf*

[4] *http://www.census.gov/acs/www/methodology/response_rates_data/*

[5] *Please note that we have used 2010 ACS data in this report and in support of the model because the 2011 data will not be available until September or October 2012*

As the table above shows, determining the number of uninsured in Hawai'i could largely depend on the data source reviewed. Between Gallup and ACS, there is a difference of about 40,000 individuals. The reader must understand that the data in some cases are subject to this degree of uncertainty. There will be no perfect picture of Hawai'i's population at the end of the report. As we proceed with modeling the migration of these individuals across different modes of insurance, it will be our task to assess the range of possible responses to the ACA's incentives. It will also be our task to assess the range of possible error in the starting assumptions.

Additional Medicaid Edits

During our review of the ACS data, there were clear inconsistencies with two external sources. First, the Med-QUEST Division identified Medicaid enrollment at the beginning of 2010 totaling 254,000;[6] the ACS data only accounted for 204,000 Medicaid enrollees. Second, statutory financial statements filed by insurers in Hawai'i's market suggest that the ACS overstated those residents with Direct Purchase coverage by approximately 40,000.

We first note that Med-QUEST's reports reflect what would seem to be the upper limit of possible Medicaid enrollment. Medicaid enrollees in households with enrolled children are passively re-enrolled.[7] In addition to passive enrollment, there are other potential sources for data differences. First, in the ACS, the US Census Bureau attempts to address the Medicaid undercount phenomenon identified above. However, their edits do not account for coverage of low-income childless adults. Although the ACS may do a good job of adjusting those enrollees that would traditionally qualify for Medicaid (e.g., Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI)), they have no edits for non-traditional enrollees (e.g., those that would qualify for the QUEST-Net and QUEST-ACE programs). In addition, there may be Compact of Free Association (COFA) enrollees recognized in the Medicaid program that are not recognized in the ACS. According to DHS, they estimate that there are between 10,000 and 12,000 COFA enrollees with Medicaid coverage; ACS recognizes only 5,000. Third, with the disruption to the economy in 2008 and 2009, we would expect volatility (and thus, inconsistency) in enrollment estimates as the number of Medicaid covered persons grows.

Although we were unable to fully reconcile these Medicaid enrollment inconsistencies, we did reclassify a number of people in the ACS data into Medicaid that were not originally identified in that program. Specifically, we revised the insurance classification to "Medicaid" for individuals who indicated they had Direct Purchase coverage who also satisfied one of the following criteria:

- Household earnings below 200% FPL (or whose income was not identified)
- Under the age of 18 with household income less than 301% of FPL

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[6] *http://www.med-quest.us/ManagedCare/MQDquestenroll.html; for 2012, the enrollment is closer to 287,000*

[7] *OW teleconference call with DHS on August 1, 2012*

- Over the age of 17,[8] not the primary resident, with household income over 200% of FPL, and personal income less than $20,000

This process reclassified approximately 31,000 individuals from Direct Purchase to Medicaid. To support these modifications, we note (as indicated above) that the Direct Purchase counts in the ACS data were approximately 40,000 enrollees higher than what was shown in the publicly available financial statements for commercial carriers. We assumed that anyone eligible for coverage under QUEST-Net or QUEST-ACE would obtain that coverage rather than purchase an individual policy even if the coverage was not as comprehensive in 2010. We also assumed that any child eligible for CHIP would be enrolled in that program even if his or her parents had purchased an individual policy. Finally, we assumed that there may be persons who still reside with their parents, who do not qualify for coverage as a child under their parents' policies, and who can obtain coverage under QUEST-Net or QUEST-ACE.

In any other cases, when we have become aware of clear inconsistencies between the ACS data and an alternative, reliable source, we have presented that source and the possible consequences of these inconsistencies.

Medical Expenditure Panel Survey

We also used the Agency for Health Care Research and Quality's MEPS data from 2010 to develop characteristics of Hawai'i's small employer market. MEPS identifies key statistics for the small employer market by state, including employer offer rates, employee take-up rates and premiums by tier. All statistics in the MEPS data are available by various group sizes.

Annual Financial Statement Data

We used annual financial statements to identify total enrollment, premium, claims and other data for Hawai'i's individual, small group, and large group insurance markets. Although we also reviewed prior years' data, the primary source for this work was the 2010 and 2011 Annual Statutory Financial Statements filed on the Health or the Life, Accident and Health (LAH) Statement. To support new insurer reporting requirements, 2010 and 2011 Annual Statements include a new schedule, the Supplemental Health Care Exhibit. Insurers are required to report this schedule separately for each state in which they write comprehensive major medical business.[9] The Supplemental Health Care Exhibit reports detailed income statement data based on individual, small group employer, large group employer, government business, other business, other health and uninsured plans. Small group employers are defined as groups with up to 100 employees,[10] except in states exercising an option under the ACA to define small

[8] *The coverage expansion for dependents to age 26 was implemented in September 2010. Because we are approximating the March 2010 population, we are segmenting dependents at age 18.*

[9] *Experience for individual plans sold through an association or trust is allocated to the state issuing the certificate of coverage. Experience for employer business issued through an association or trust is allocated based on the location of the employer. Experience for group plans with employees in more than one state is allocated to state based on situs of contract.*

[10] *Sole proprietors are not considered a small group under the ACA and will not be eligible to enroll in the SHOP Exchange.*

groups as those with up to 50 employees until 2016. The large group employer category includes the Federal Employees Health Benefit (FEHB) program and state and local fully insured government programs. We obtained access to the Annual Statutory Financial Statement data through a subscription service.

Carrier Data Call

In order to review the current product offerings, premiums and rating structures used by carriers offering coverage in the individual and small group markets, we issued a carrier data request. In this request, we asked that carriers in Hawai'i provide distributions of their enrollees by line of business; we also asked that they provide information about current rating practices.

This information enhanced several aspects of our background research related to the individual and small group markets. We note that in these assessments we supplemented this information with other information such as product brochures gathered from carrier's websites. From these response data, we hope to assess the disruption that might occur in the market with the implementation of the ACA.

As none of the sources of information described above contains a complete picture of the current market, we combined the data from each source to establish the 2010 baseline profile of Hawai'i's insurance marketplace and individuals expected to be eligible for coverage through the Hawai'i Connector in 2014. To ensure data consistency, we compared various summaries of the data across independent sources. Our process of validating these data also highlighted how the various sources overlap and/or fit together and ensured the combined information on which the model estimates are based made sense. Where necessary, we smoothed results so that the final baseline profile presents a coherent, internally consistent picture of the current environment.

Throughout this report, distributions based on FPL are built from the ACS's definition of income and FPL. Starting in 2014, the IRS will use a new definition of family size based on the number of personal exemptions that an individual claims on his or her tax return for determining eligibility for premium credits. However, we do not believe this change to the definition of household income will have a material impact on our findings.

While we have reviewed each of these data sources for reasonableness, and where discrepancies arose we performed further investigation to reconcile any differences, we have not independently audited any of these data.

Finally, please note that some exhibits show population distributions where the figures are rounded. In several cases, the sum of the rounded values from those distributions may not equal 100%. We have tried to provide total estimates for these distributions, but the reader should be aware that the total estimates will not agree with the sum of each weight.

4

Overview of Hawai'i's Current Health Insurance Market

Hawai'i's geography, significant military presence, employer regulations, and existing public programs make it unique among the states and how it will be affected by the ACA. In this section, we will discuss in more detail some of those qualities that make Hawai'i unique. We provide an estimate of how prevalent modes of coverage are employed among Hawai'i's residents, and we introduce those components of the ACA that we expect will most influence the viability of the Hawai'i Connector.

The Hawai'i Connector is intended to provide a robust marketplace where individuals and small employers will be able to shop for health coverage. Additionally, it is expected to provide greater transparency for these purchasers by grouping plans with similar actuarial values and clearly indentified premiums. The viability of the Hawai'i Connector will depend both on the number of participants and the willingness of carriers to offer coverage through them.

There are numerous distinguishing features that make Hawai'i unique among the states. Although we will use later sections to explore some of these features in more depth, there are three features of Hawai'i's health insurance market that we introduce here. First, Hawai'i has a much larger military presence as a percentage of the population than the rest of the country. As of 2010, the ACS data show that nearly 7% of Hawai'i's population received health coverage through the military; less than 2% of the nationwide population is insured through military coverage.

Second, Hawai'i's Prepaid Health Care Act (PHCA) ensures that employers in the State provide coverage to their workers at a much higher rate than do employers in the rest of the country. According to the ACS, nearly 60% of Hawai'i's residents (both active and retired) receive some level of coverage through an employer (e.g., their employer, their spouse's employer, etc.). For the country as a whole, 53% of individuals obtain coverage from an employer. We anticipate that the presence of the PHCA will strongly affect how the ACA influences Hawai'i's health insurance marketplace.

Third, Hawai'i already has experience with an expanded Medicaid program. Hawai'i's QUEST program began as a demonstration waiver (1115a) in August 1994. And through the QUEST-Net and QUEST-ACE programs, Hawai'i has provided some level of coverage to low-income, childless adults. Although the total percentage of the State's population in Medicaid is comparable to the rest of the country, there are far more adults in Hawai'i's Medicaid program.

As a consequence of these three dynamics, Hawai'i also has a much lower rate of uninsured persons than the rest of the country. The following table shows our estimates of enrollment in

2010 both for Hawai'i's residents and the country as a whole. (Please note that the estimates of persons and standard deviations are in 1,000's).

Table 4.1
Coverage Summaries (in 1,000's)

	Hawai'i			Nation		
Coverage	Persons	Distribution	Stand Dev +/-	Persons	Distribution	Stand Dev +/-
Employer (non-Medicare)	717	52.6%	4.7	148,868	48.2%	70.9
Employer (Medicare)	95	7.0%	1.3	13,668	4.4%	16.6
Military (Active)	93	6.8%	2.3	5,236	1.7%	17.5
Military (Retired)	1	0.1%	0.2	357	0.1%	3.3
Direct Purchase	44	3.2%	1.6	16,616	5.4%	34.0
Medicare	77	5.6%	1.4	22,455	7.3%	20.0
Medicaid	193	14.2%	3.5	43,541	14.1%	49.9
Dual	39	2.9%	1.4	9,815	3.2%	19.2
No Coverage	104	7.6%	2.2	48,257	15.6%	48.1
Total	1,363	100.0%		308,813	100.0%	

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Based on the hierarchy that we applied to the ACS data, the table shows that approximately 104,000 residents of Hawai'i are uninsured. As a percentage of the population, the 7.6% estimate of the uninsured also compares favorably with an estimate prepared by the Kaiser in 2010.[11] Next, the table shows that approximately 211,000 residents are covered by Medicare (i.e., retirees with employer administered benefits, those with Medicare alone and those residents dually eligible for Medicare and Medicaid). We do not expect the presence of the Hawai'i Connector to substantially affect the coverage for those residents under Medicare or TriCare. Also, the estimate is consistent with estimates of the Medicare eligible population as identified by CMS (i.e., 204,000).[12] The table shows that the number of residents covered by Direct Purchase insurance is approximately 44,000. This is somewhat higher than the membership (i.e., 31,000) reported in 2010 statutory financial statements by insurance companies with products in Hawai'i. There are multiple reasons why these enrollment figures may be higher than expected. For example, the ACS data may include persons who have

[11] *Lee, Dr. Sang Hyop. 2011. Hawai'i's Uninsured Population Update. Kaiser Permanente.*

[12] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration-Items/CMS1234724.html*

coverage through COBRA (who should be classified as ESI). Finally, the table shows that Hawai'i's Medicaid enrollment was approximately 232,000 in 2010 (Medicaid eligible and dually eligible residents). As discussed in the Data section, this estimate is lower than what is directly reported by the Med-QUEST Division, but higher than what is reported in other survey data.

Because residents can reflect multiple modes of insurance through the ACS, we must classify these individuals into a single category to ensure that we do not double count them. Our hierarchy is very aggressive in assigning enrollees to Medicaid.[13] That is, the hierarchy automatically assigns enrollees to Medicaid if they show any indication of Medicaid coverage. We have not removed anyone from these estimates; so, they may be somewhat different than what is shown on the US Census Bureau's website. Finally, in addition to best estimates, we have included estimates of standard deviation; the ACS provides the tools to prepare these measures. As we model migration, we can employ ranges implied by these statistics to reflect potential statistical error in our starting assumptions.

Key Provisions

There are several key elements of the ACA that we expect will affect how individuals move between their current coverage (or non-coverage) and other coverage modes. As we reviewed Hawai'i's population, we tried to identify those characteristics that would most likely interact with the provisions of ACA. In the following paragraphs, we describe the provisions on which we put particular weight.

The ACA introduces a number of new rating requirements for insurers offering coverage in the individual and small group markets beginning in 2014. Specifically, insurers will no longer be allowed to deny coverage for pre-existing conditions, they will no longer be allowed to rate based on morbidity, gender, industry or group size, and they will be limited in how they are allowed to vary rates based on age.

In general, the ACA's restrictions will have the effect of increasing rates for the young, for males in younger age ranges and for the healthy. They will likely also lower rates for the elderly, for females in younger age ranges, for the unhealthy and for those in very small groups or industries that tend to exhibit higher than average morbidity. These restrictions will limit the extent to which carriers can reflect differences in risk when setting premium rates. (Over time, and in the absence of other requirements, these new restrictions may drive the young and the healthy out of the market or to alternative sources of coverage. The Department of Health and Human Services (HHS) is attempting to mitigate these dynamics in the individual and small group markets by implementing a risk sharing mechanism that will require insurers with healthy enrollees to subsidize insurers with less healthy enrollees. From 2014 to 2016, a transitional reinsurance program is also being implemented in the individual market to help reduce rate

[13] *Appendix C*

shock that might otherwise occur due to high risk individuals entering that market. These programs will be available for plans in the individual and small group markets.)

In addition, the government will now levy annual fees on health insurers of $8 billion starting in 2014 and increasing to $14.3 billion by 2018.[14] The fees will be apportioned based on the insurer's market share, with tax exempt insurers considering only 50% of premium in calculating market share and self funded plans excluded. State managed Medicaid programs and Medicare Advantage plans will also be subject to these fees. Much of the ultimate cost of these fees will likely either be passed on to the insurers' members or put additional pressure on state Medicaid budgets. Some parties have estimated the effect of these fees on premiums to be in the range of 2% to 3%.[15]

Under the ACA, insurers must offer qualified health plans, which satisfy requirements related to marketing, networks, covered benefits, etc. In addition, insurers must offer coverage for these qualified health plans with cost sharing at specific actuarial values. The law identifies these values as Platinum, Gold, Silver, and Bronze (with corresponding actuarial values of 0.9, 0.8, 0.7, and 0.6, respectively). Insurers must offer both Silver and Gold plans if they participate in the Exchange.

Central to the ACA is an individual mandate that imposes a penalty or tax for those individuals who do not maintain minimum essential coverage. The mandate is not universal and provides an exemption for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income).[16] The penalty is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015, and 2.5% in 2016) with the tax reflecting the larger amount. For a single individual earning $25,000 per year (or approximately 220% FPL in 2010), the penalty would be the following:

Table 4.2
ACA Individual Mandate Example

	2014	2015	2016
Income*	$25,000	$25,000	$25,000
Flat Tax Amount	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Tax	$250	$500	$695

*Assumes no wage inflation

[14] *The Health Care and Education Reconciliation Act, Subtitle E, Section 1406*

[15] *http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf*

[16] *Exemptions include those below with income below the filing threshold, those belonging to Native American tribes, those in prison, undocumented individuals, those with hardship exemptions, and those with religious exemptions.*

Please note that our micro-simulation model reflects individual preference regarding the value of coverage and its cost relative to fees for being uninsured.

The ACA will provide tax credits to eligible individuals and families with incomes up to 400% of FPL toward the purchase of a qualified health insurance plan through the Hawai'i Connector. Credits will be determined based on the Silver plan in the Connector with the second lowest premium. The credits will be set so that the premium will be limited to a certain percentage of income (on a sliding scale). The following table shows sample income and tax credit levels for an individual related to a theoretical plan level with a monthly premium of $430:

Table 4.3
Sample Income and Tax Credit Levels

Sample FPLs	Income	Plan Cap %	Plan Cap $	Plan Cost*	Tax Credit
133%	14,815	2.0%	296	5,160	4,864
175%	19,493	5.2%	1,004	5,160	4,156
225%	25,063	7.2%	1,798	5,160	3,362
275%	30,632	8.8%	2,688	5,160	2,472
325%	36,202	9.5%	3,439	5,160	1,721

*Assuming this represents the cost for the second lowest cost Silver plan sold through the Connector

Ultimately, the individuals are not obligated to participate in a certain plan level. They may participate in a plan with additional benefits or lower cost sharing, but the tax credit will be calculated relative to the plan index cost (i.e., the Silver plan in the Hawai'i Connector with the second lowest premium).

The ACA requires an annual assessment from large employers (those with 50 or more full-time equivalent employees) that do not offer minimum essential health coverage to their employees. This assessment is equal to $2,000 per employee with a disregard for the first 30 employees. For example, an employer that did not provide coverage to its 250 full-time employees would face a penalty of $440,000 = (250 – 30) x $2,000. Similarly, large employers that do offer coverage and whose employees enroll through the Connector (as a result of eligibility for tax credits) will face an assessment of $250 per month for each month the employee receives coverage through the Connector. In a following section, we discuss the provisions of Hawai'i's PHCA and the incentives that it provides employers. We expect that the PHCA provisions will mitigate the effect of any employer penalty for non-coverage in the ACA.

Beginning in 2014, the ACA extends Federal funding to states that provide Medicaid coverage to individuals who are not Medicare eligible and have incomes below 138% of FPL (133% of FPL with a 5% disregard), regardless of their assets. Hawai'i already has expanded coverage for these childless, low-income adults, and the Federal government will pay a larger share of the cost for covering these individuals starting in 2014 (with funds increasing to 90% by 2020). Effective July 2012, Hawai'i introduced changes to the Medicaid program and how it provides

coverage to childless adults. In particular, the State decreased eligibility income thresholds for childless adults from 200% of FPL to 133% of FPL.

There are a number of other changes to the Medicaid program under the ACA. In particular, it requires that Hawai'i be able to enroll Medicaid eligible residents in Medicaid through the Hawai'i Connector (if that person is found to be eligible as a result of application for coverage through the Connector).

The ACA also provides states the option of establishing a Basic Health Program (BHP) under which a state may enter into contracts for offering one or more health plans providing at least the essential health benefits to eligible individuals.[17] The BHP is intended to smooth the transition between Medicaid and commercial coverage for those enrollees between 138% and 200% FPL (and below 133% FPL for lawfully present immigrants). There is evidence that this population transitions in and out of Medicaid eligibility with some frequency — the BHP is designed to ensure that there is limited disruption in coverage or access.

[17] *Eligible individuals are those with incomes between 133% and 200% of FPL (below 133% of FPL for lawfully present immigrants), are not eligible for Medicare, and do not have access to affordable ESI that provides minimum essential coverage.*

5

Hawai'i's Private Employer Market

In this section, we examine Hawai'i's private employer market. We first present specific provisions of the PHCA. An understanding of the PHCA and how it interacts with the ACA will be critical in anticipating employers' responses to the new health reform law. We also examine new incentives facing Hawai'i's employers under the ACA. Next, we present characteristics of Hawai'i's employers and their employees without regard to insurance coverage status. We then examine the subset of workers that have employer sponsored insurance (ESI) coverage. Finally, we present new small group rating requirements under the ACA.

Prepaid Health Care Act

The PHCA was enacted in 1974, and although it does not apply to government workers and certain other industries (e.g., seasonal agricultural workers); it has a substantial effect on Hawai'i's ESI market. The PHCA requires that applicable employers in Hawai'i provide health care coverage to employees who work twenty hours per week and earn 86.67 times Hawai'i's minimum wage over the course of a month. These coverage requirements begin after an employee has worked for his or her employer for four consecutive weeks.

The PHCA also prescribes certain other requirements. For example, all benefit designs must meet certain minimum standards as determined by the DLIR. The DLIR makes this determination with the assistance of a PHC Advisory Council, which is made up of representatives of various groups. The minimum standards for benefit designs apply to both self-funded employers and those purchasing coverage from insurers. Employers can offer a 7a plan (the prevalent plan), which includes benefits equal to or better than those offered by the plan with the most subscribers in the State. Currently, the prevalent PPO plan has a $100 deductible and 90% in-network coinsurance (with some services at 80%), and under it, the employer is not obligated to pay for any part of dependent coverage.[18] Alternatively, employers can offer a 7b plan, which has a more limited benefit design than the prevalent plan. However, employers that offer the 7b plan are then obligated to pay 50% of the dependent premium. Currently, the 7b plans have a $300 deductible and 80% coinsurance.

Under certain circumstances, employees can waive the mandated coverage. If, for example, an employee is covered through Medicaid, Medicare, or an approved plan, they can complete a notification form for their employer, effectively exempting the employer from its health care coverage responsibilities under the PHCA. However, if the employer does provide coverage, not

[18] http://hawaii.gov/labor/dcd/PDF/PHC/HMSA%20HC-7-a-1-%20-Rev%2009-11.pdf

only must the coverage satisfy minimum benefit requirements, it must satisfy certain contribution requirements as well. Under the PHCA, employees can be required to contribute up to the lesser of 50% of plan cost or 1.5% of income; for most employees, contributions will almost always be capped at 1.5% of income. This contribution requirement is critical in understanding how the ACA will affect employee behavior. Employees will only be eligible for tax credits in the individual exchanges if they can demonstrate that their contributions for employer sponsored coverage are more than 9.5% of their income. Consequently, anyone whose employer complies with the PHCA is unlikely to qualify for tax credits in the Connector.

The PHCA imposes certain penalties for employers that do not comply.[19] For example, an employer that does not provide coverage to eligible employees will be penalized $1 per day per employee for the time during which they were non-compliant. Also, an employer that willfully fails to comply with any provision of the PHCA can be fined $200 for each violation. Perhaps the most compelling provision is the following: any employer who fails to provide coverage to eligible employees will be liable to pay for health care costs incurred by these employees during the period in which the employer was non-compliant. An employer that does not provide coverage to an eligible employee faces significant risk if the employee becomes ill. In addition to the financial incentives for providing coverage, there is also likely additional difficulty in attracting employees that might have other job opportunities with employers that do offer coverage.

Based on discussions with the DLIR, we suspect that neither the 7a plan (i.e., the Prevalent Plan) nor the 7b plan will have an actuarial value near 70%, which is the actuarial value of plans at the silver metallic level. The ACA requires that carriers offer plans that provide the essential health benefits package. Based on discussions with the DLIR, some carriers currently offer parts of this package (e.g., prescription drug coverage) as a rider; they will no longer be able to market any parts of the EHB package as an add-on.

Because of the presence of the PHCA, employers in Hawai'i may be less likely than those in other states to terminate their coverage. Because many more residents of Hawai'i obtain their coverage through their employer, the Connector (i.e., the individual Exchange) may have lower participation (as a percentage of the total population) than will the Exchanges in other states. If this high coverage rate among employers persists, fewer Federal funds in the form of tax credits would come into the State. In addition, the cost per enrollee to run an Exchange will be higher with fewer enrollees.

Employer Incentives

The ACA introduces several new rating requirements for insurers. Although we have discussed some of these requirements in a previous section, we continue our discussion of specific requirements in this section. In general, the new regulations are expected to increase premiums for some groups and decrease them for others. The premium disruption will depend on the

[19] *http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0393*

demographic composition of the group, the group's current morbidity load, and the efficacy of a new risk sharing mechanism. This new risk sharing mechanism will require small group insurers with healthy enrollees to subsidize insurers with less healthy enrollees.

The ACA includes other provisions that will affect premiums in the group market. First, the government will assess new fees against insurers; as previously identified, some estimate that these will be in the range of 2% to 3% of premium.[20] In addition, there are several other new taxes and fees (such as fees assessed on pharmaceutical manufacturers and a 2.3% excise tax on medical devices) that will affect premium.

In the short-term, some small employers will receive incentives in the form of tax credits to offer coverage to their employees.[21] Employers with fewer than 25 full-time employees who have an average annual salary of less than $50,000 and pay at least 50% of the single premium for health insurance can receive a tax credit up to as much as 35% of the employer's contribution (25% if the employer is a non-profit) in 2010 through 2013. The maximum credit is available to employers with less than ten full-time employees and an average annual salary of less than $25,000. The credit is phased out as the number of full-time employees increase to 25 and the average annual salary increases to $50,000. In 2014 and later, employers can take the tax credits for two consecutive years, after which no additional credits are available. In these years the maximum credit is increased to 50% of the employers' contribution, with a similar phase-out schedule based on employer size and average payroll as occurs between 2010 and 2013.

Although the presence of the PHCA will likely minimize coverage attrition (among those employers to which it applies), the ACA introduces some incentives for employers to drop coverage. For example, most low-income individuals will be eligible for tax credits if they purchase coverage directly through the Connector. An employer with many low-income employees may find that it is less costly to pay the penalty and simply provide their employees with additional compensation to cover the cost of the unsubsidized portion of the premium. In this case, these subsidy-eligible employees that purchase individual coverage in the Connector might also qualify for cost-sharing subsidies. As specified though, the presence of the PHCA will likely eliminate this option for many employers.

Hawai'i's Private Employer Market

As we review Hawai'i's ESI market, it will be important that we understand the composition of those employers participating in it. When looking at distributions of private workers in each industry across the island groups, there is a clear difference in the geographic concentration of those workers. The following table shows that distribution.

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[20] *http://www.ahipcoverage.com/wp-content/uploads/2011/11/Insurer-Fees-report-final.pdf*

[21] *http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers*

Table 5.1
Employee Distribution by Industry

Industry	Island			Industry
	Oahu	Hawai'i	Kauai, Maui, Molokai	Distrubtion
Agr, Mining, Util	37.4%	33.7%	28.9%	2.8%
Const & Manu	60.6%	19.3%	20.1%	13.8%
Trade	70.7%	14.0%	15.3%	16.8%
Transp, Info, Finan	75.0%	8.6%	16.4%	11.5%
Real Estate	61.3%	11.2%	27.5%	3.8%
Prof, Sci, Tech	71.4%	10.2%	18.4%	5.3%
Mang, Admin Srv	57.4%	17.2%	25.5%	6.1%
Education	79.7%	14.7%	5.6%	3.6%
Health & Soc Srv	77.1%	11.8%	11.1%	12.1%
Arts, Ent, Food, Other	64.0%	13.5%	22.5%	24.1%
Total	67.2%	14.2%	18.6%	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the distribution of persons employed in each industry group for all islands (rightmost column); it also shows the distribution for a specific industry across each island group. For example, the column at the right shows that 2.8% of the total privately employed population is in agriculture, mining or utilities. While the preceding columns show that approximately the same number of people across each island group are employed in agriculture, mining, and utilities (at 37.4%, 33.7%, and 28.9% in Oahu, Hawai'i, and the remaining islands, respectively).

There are several notable observations from the preceding table. First, Oahu has a higher concentration of persons employed in transportation, information, and finance, as well as education and health and social services (75.0%, 79.7%, and 77.1% respectively versus 67.2% for all industries in total). Second, the other islands have a higher concentration of persons employed in construction, manufacturing and real estate as well as in agriculture, mining and utilities. For many in this second group, the PHCA does not apply. Businesses employing seasonal agricultural workers or real estate salespersons paid by commission are exempt from the law (as it applies to those workers). As such, a higher proportion of workers outside Oahu may decide to take advantage of subsidies available through the Exchanges.

As part of Oliver Wyman's micro-simulation model, we create theoretical (or synthetic groups) for estimating the possible effects of various elements of the ACA. In creating these groups, we pool persons with the same industry type; as a consequence, we are able to tailor other assumptions, like group size or participation, to specific industries. The distributions in the preceding table are critical in creating these synthetic groups.

The ACS also permits us to examine coverage status by industry for employed persons.

Table 5.2
Coverage Status by Industry

Industry	with ESI	FT Uninsured	PT Uninsured	Other Cov	Total
Agr, Mining, Util	70.2%	5.8%	5.7%	18.3%	2.8%
Const & Manu	64.9%	7.2%	8.2%	19.7%	13.8%
Trade	69.8%	3.9%	5.9%	20.4%	16.8%
Transp, Info, Finan	75.1%	4.3%	4.7%	15.8%	11.5%
Real Estate	69.8%	2.4%	4.4%	23.4%	3.8%
Prof, Sci, Tech	69.6%	4.9%	4.6%	20.8%	5.3%
Mang, Admin Srv	65.0%	7.3%	10.0%	17.7%	6.1%
Education	72.1%	1.3%	4.2%	22.4%	3.6%
Health & Soc Srv	78.0%	2.9%	3.4%	15.7%	12.1%
Arts, Ent, Food, Other	66.7%	4.7%	8.4%	20.2%	24.1%
Total	69.8%	4.6%	6.4%	19.1%	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As with the preceding table, the distribution in the rightmost column shows private employment by industry. Each column on the rows preceding those entries show how the employed population is distributed for each specified status. For example, the table indicates that 12.1% of privately employed persons work in health and social services. Among those employed persons, 78% have health insurance through an employer.

Please note that we identify full-time workers as those who have worked 35 hours or more in the week preceding the response to the ACS questionnaire. The ACS does not provide information with the detail that would be necessary to assess coverage eligibility under the PHCA. Also, the ACS does not specify whether coverage is obtained through the respondent's employer or someone else's employer. For example, a real estate agent might have coverage through his wife who works as a health care worker. This theoretical person would contribute weight to the 'real estate employee with ESI' cell even though the coverage in that case is not truly associated with the industry. (We do not think this introduces error unless there is reason to suspect a systematic bias in coverage. For example, if we thought most real estate agents were married to health care workers, such a dynamic could produce a bias in our estimates.)

On average, about 69.8% of private employees have coverage through an employer. The table identifies some industries in which workers are more likely to be covered by an employer (e.g., health and social services at 78.0% and transportation, information, and finance at 75.1%). We have already noted geographic differences in distributions of employment by industry. It is not clear that persons are more or less likely to have coverage because of the industry in which they work (e.g., health and social services) or because of the place in which they work (e.g., Oahu).

Data sources beyond the ACS allow us to examine other characteristics of Hawai'i's private employer market. The following table is from the 2010 MEPS data summaries, and it shows distributions of private employees by group size.

Table 5.3
Group and Employee Distributions (Private)

Organization	Hawai'i		Nationwide	
Employees	Groups	Employees	Groups	Employees
2 to 9	55%	12%	58%	12%
10 to 24	13%	9%	12%	9%
25 to 99	10%	18%	8%	14%
100 to 999	8%	19%	7%	18%
1,000 or more	15%	42%	15%	47%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

Please note the group size classifications are determined at the organization level. For example, the employees at a large chain, fast food restaurant might be classified in the largest group size even though the particular establishment responding to the MEPS questionnaire might only employ a few dozen people.

Although employers in the mid group market (i.e., 25 to 99) are proportionally larger in Hawai'i than in the country as whole, the table shows that the composition of groups by organization size in Hawai'i is very similar with the nationwide composition. The MEPS data yield some other interesting observations about Hawai'i's private employers. For example, MEPS reports the average nationwide single premium as $4,940 for employees at establishments that offer coverage. In Hawai'i, the corresponding single premium estimate is $4,294; this estimate is also reported with an average deductible estimate that is lower in Hawai'i than in the country as a whole.

The following table, also from the 2010 MEPS data, highlights how unique coverage rates are in Hawai'i's employer market relative to the country as a whole. Coverage is offered at a much higher rate in all group sizes. In total, 84.7% of employers in Hawai'i offer coverage, while only 53.8% of employers nationwide do. This difference is particularly striking among groups with fewer than 25 employees. In Hawai'i, 77.2% employers in this segment offer coverage; for the whole country, 36.7% of employers in this segment offer coverage. As a consequence, a larger percentage of small group employees will likely be eligible to enroll in the Hawai'i SHOP Exchange than will employees of groups this size in other states. However, the ultimate decision to enroll in the SHOP lies with the employer; even if the potential market for the SHOP is relatively large, potential enrollment is no guarantee of participation. The enrollment will ultimately depend on the SHOP's appeal to employers.

Table 5.4
Employee Contribution Rates

Hawai'i

Employer Size	% of Establishments Offering Coverage	Employee Contribution	Employee % of Total	Family Contribution	Family % of Total
2 to 9	73%	$223	5%	$1,330	11%
10 to 24	94%	$108	2%	$2,327	20%
25 to 99	100%	$266	6%	$3,112	26%
100 to 999	100%	$597	14%	$4,945	41%
1,000 or more	100%	$633	15%	$3,060	25%

Nationwide

Employer Size	% of Establishments Offering Coverage	Employee Contribution	Employee % of Total	Family Contribution	Family % of Total
2 to 9	32%	$857	16%	$3,208	24%
10 to 24	61%	$889	18%	$4,427	33%
25 to 99	81%	$1,009	21%	$4,574	35%
100 to 999	95%	$1,081	21%	$4,050	29%
1,000 or more	100%	$1,044	21%	$3,443	24%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

In addition to showing offer rates, the table also shows annual employee contribution rates for single and family coverage. In particular, the average contribution rates for single employees are lower for all group sizes in Hawai'i than they are nationwide. The table also shows that average family contribution rates for groups with 100 or more employees are higher in Hawai'i than they are nationwide. We suspect that these higher contribution rates are present because the PHCA does not require employers to contribute to dependent coverage under the prevalent plan.

According to the MEPS data, 98% of all employees working for a private employer in Hawai'i work for an employer that also offers coverage. Of those employees, only 80% are eligible for coverage, and of those that are eligible, only 84% enroll in the plan. This means that 67% (= 80% x 84%) of employees working for a private employer offering coverage are actually enrolled in the plan. The corresponding estimate for employees nationwide is 60%. For the whole country, 78% of employees that work for employers offering coverage are eligible; of these nationwide employees, only 77% of them actually enroll. Not only do more employees in Hawai'i work for employers offering coverage, but those that are eligible, enroll at a higher rate (84% versus 77%).

There are several possible reasons why only 84% of the employees in Hawai'i who are eligible for coverage are enrolled. First, some may find that coverage offered through their spouse's employer is more affordable (e.g., $0 premium). Further, some employees, particularly those in

good health, may perceive the value of coverage to be less than the cost. Finally, some employees may have coverage through other means (e.g., through Medicaid).

The table below shows the distribution of the previously mentioned 67% enrollment rate in Hawai'i and the 60% enrollment rate nationwide by group size. The table shows that, for both large and small groups, the enrollment rate for private sector employees who are offered ESI coverage is higher in Hawai'i than it is for the nation as a whole. This higher rate of enrollment is principally due to higher take-up of coverage among employees that are eligible for it.

Table 5.5
ESI Coverage by Group Size Among Private Sector Employees

	Hawai'i		Nationwide	
	Distribution of Employees	% Covered by Employer	Distribution of Employees	% Covered by Employer
Group Size				
2 to 9	12%	72%	12%	64%
10 to 24	9%	70%	9%	57%
25 to 99	18%	71%	14%	56%
100 to 999	19%	69%	18%	58%
1,000 or more	42%	62%	47%	61%
SG & LG				
0 to 49	29%	70%	28%	59%
50 or more	72%	65%	73%	60%
Total	100%	67%	100%	60%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

It is also worth noting that a larger proportion of Hawai'i's private employees work in groups with 25 to 99 employees (relative to the nation as a whole), while there is a lower representation of private employees in groups with 1,000 or more employees.

In addition to examining employers and their coverage tendencies, it is also important to examine the characteristics of the Hawai'i's employees that are covered by ESI. The following table shows the distribution of active employees of groups by age and gender:

Table 5.6
ESI Enrollment Rates (Active Private Employees)

	Hawai'i		Nationwide	
Age Band	Male	Female	Male	Female
0 to 17	11.7%	10.7%	12.6%	12.0%
18 to 24	4.8%	3.9%	4.7%	4.7%
25 to 29	3.5%	3.7%	3.2%	3.6%
30 to 34	3.9%	3.7%	3.6%	3.9%
35 to 39	4.7%	4.1%	3.9%	4.2%
40 to 44	4.1%	4.7%	4.3%	4.5%
45 to 49	4.8%	4.7%	4.6%	5.0%
50 to 54	4.4%	5.0%	4.6%	5.0%
55 to 59	4.3%	4.6%	4.0%	4.4%
60 to 64	3.9%	4.1%	3.3%	3.5%
65+	0.4%	0.5%	0.3%	0.3%
Total	50.5%	49.5%	49.1%	50.9%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, there are not substantial differences between Hawai'i's age and gender composition and the composition for individuals from the rest of the country. Other than enrollment of child dependents, the number of persons covered by ESI appears to peak around the 45 to 54 age ranges. We also note that, with some minor exceptions, enrollment for men and women tracks very closely between Hawai'i and the nation as a whole.
In addition to demographic estimates, we can also examine coverage through ESI by income level. The following table shows the distribution of active employees of private groups by their relationship to FPL:

Table 5.7
ESI Coverage (in 1,000's)

	Hawai'i		Nationwide	
FPL	Persons	Percentage	Persons	Percentage
0 to 100%	36	5.0%	7,704	5.2%
101% to 138%	17	2.4%	4,214	2.8%
139% to 200%	37	5.2%	11,173	7.5%
201% to 300%	113	15.8%	24,231	16.3%
301% to 400%	137	19.0%	25,214	16.9%
401% +	377	52.5%	76,332	51.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Consistent with the country as a whole, Hawai'i's residents with ESI are weighted toward the higher income ranges specified here. Given the contribution requirements of the PHCA, it is somewhat surprising that there are not more ESI enrollees at the lower income levels. In fact,

the table shows that there are a higher proportion of individuals with ESI at the higher income ranges (i.e., above 300% of FPL) in Hawai'i than in the rest of the country.

Fully Insured Group Coverage Offered in Hawai'i

Beginning in 2011, the ACA implemented rules that require carriers to meet new minimum loss ratio requirements separately for the small group and large group markets. Carriers that do not meet the loss ratio requirements must refund premiums to policyholders. In order to support enforcement of these new rules, Statutory Financial Statements now include a Supplemental Health Care Exhibit that permits review of each carrier's experience by line of business.

The following table provides a summary of the 2011 large group experience (51 employees or more) for each carrier in the Hawai'i market.

Table 5.8
Large Group Carriers

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	3,928,805	$275.45	$247.95	90%
Kaiser Foundation Health Plan Inc	1,625,121	305.09	295.66	97%
University Health Alliance	223,800	129.42	118.77	92%
Hawai'i Management Alliance Assn	228,897	227.04	204.12	90%
Kaiser Permanente Ins Co*	80,186	66.71	58.66	88%
Total	6,086,809	$273.42	$251.79	92%
Average	507,234			

*Kaiser Permanente is part of Kaiser Foundation Health Plan, but files separately for their OON POS benefits

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table shows that approximately 507,000 individuals were covered under a fully insured large group policy in 2011. These individuals are covered by five carriers (under four organizations) that filed statutory financials for group business in Hawai'i. Of those five, over 90% of individuals covered in large groups are covered by the top two carriers, Hawai'i Medical Services Association and Kaiser Foundation Health Plan, Inc. Although there is some variation of loss ratio by carrier, the aggregate loss ratio is consistent with our expectations for large group blocks of business. (Please note member months reflect covered individuals, not employees)

Although reported premiums vary by insurer, it is important to note that the premiums in the table above reflect the underlying differences in demographics and benefits.

For several reasons, we anticipate that a majority of the individuals covered by large groups are unlikely to participate in the Connector or the SHOP (at least until 2017). First, states may expand the SHOP to include large employers starting 2017, but until then, large groups are not eligible to enroll in them. Second, the PHCA provides large employers significant financial incentives to maintain coverage for their employees. It is unlikely that these groups would drop coverage and move the enrollees into the individual Connector.

As noted, the Supplemental Health Care Exhibits also provide carriers' experience for small group (50 employees or less). The following table provides a summary of that experience in 2011.

Table 5.9
Small Group Carriers

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	917,694	$373.32	$329.75	88%
Kaiser Foundation Health Plan Inc	316,553	298.39	261.77	88%
University Health Alliance	275,599	123.21	97.71	79%
Hawai'i Management Alliance Assn	268,564	250.32	200.72	80%
Kaiser Permanente Ins Co	30,021	72.27	49.40	68%
Total	1,808,431	$298.82	$258.67	87%
Average	150,703			

*Kaiser Permanente is part of Kaiser Foundation Health Plan, but files separately for their OON POS benefits

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table identifies approximately 151,000 individuals that were covered under a small group policy in 2011. Of the carriers offering small group coverage, Hawai'i Medical Services Association is still the largest based on enrollment. However relative to large group carriers, we see a larger proportion of enrollment (i.e., about 30%) covered by the two smallest carriers (i.e., University Health Alliance and Hawai'i Management Alliance Association, but excluding Kaiser Permanente). The small group market shows less concentration than the large group market.

We note that the small group premiums are almost 10% higher than the large group premiums. Although there are no clear indications of what may cause these premium differences, there are a number of possible reasons. These reasons include but are not limited to differences in demographics and benefit offerings, differences in mix by industry, greater anti-selection in the small group market, and lower administrative expenses on a per member basis in the large group market.

The loss ratios for small group lines of business are also slightly more volatile across carriers than are the loss ratios across carriers for large group lines of business. For the entire small group market, the observed loss ratio (i.e., incurred claims divided by premium) in 2011 was 87%.

In order to demonstrate compliance with the minimum loss ratio requirements, carriers are allowed to make several adjustments to the raw loss ratio. For example, carriers may increase claims in the numerator for expenses related to quality improvement activities; similarly, carriers may lower the premium in the denominator to recognize certain taxes and fees. These adjustments are carrier specific and increase the "adjusted" loss ratio. In addition, the minimum loss ratio regulations prescribe a credibility adjustment based on each carrier's enrollment; this

adjustment also serves to increase the "adjusted" loss ratio. Although a carrier may show a loss ratio below the required minimum (e.g., University Health Alliance in the table above), they may not owe policyholders a premium refund once the loss ratio calculation includes these additional adjustments.

Rate Development in the Small Group Market

Hawai'i's small group market is currently defined as employers with two to 50 employees. We note that the ACA defines small group as at least one but no more than 100 employees on business days during the preceding calendar year. The ACA allows states to substitute "50 employees" for "100 employees" in the definition until 2016. Therefore, Hawai'i can continue to use its current definition of small group until 2016. We also note that, while the ACA definition of small group includes groups of one, recently released regulations related to establishment of Exchanges indicate that coverage for only a sole proprietor would not constitute a group health plan under the Employee Retirement Income Security Act (ERISA). These sole proprietors would not be entitled to purchase coverage in the small group market under Federal law, and therefore, it appears that these groups of one would not be eligible to participate in the Hawai'i SHOP Exchange.

There are a number of provisions within the ACA that can change either the average premium or the premium charged to a specific small group, or both. In order to better understand these changes in Hawai'i's small group market, Oliver Wyman submitted a data request to carriers asking that they provide information about their current blocks of business. Because of the number of responses, we are unable to provide information about the carriers' rating methods without potentially revealing information about specific carriers. However, we can discuss what changes in the ACA will mean in general terms for the small group market. For example, we can specify that some carriers do not use all rating tools available to them (e.g., rating by industry). Rate shock for groups with these carriers will be mitigated because their carrier does not employ all of the soon-to-be prohibited tools. And, there are some carriers that employ rating elements (morbidity, group size) that will no longer be permitted after 2013. We discuss these changes in the following paragraphs with some additional detail.

First, health plans will no longer be allowed to rate small groups based on their health status.[22] This provision will tend to lower premiums for those groups with employees in poor health, while increasing premiums for those employees in good health. From the carrier responses, we do see that some groups will be affected by the elimination of health status as a rating characteristic.

Second, health plans will be limited in their ability to rate groups based on the age of their employees, and will no longer be able to rate based on gender, group size or industry.[23] These

[22] Section 2701(a) of the ACA

[23] Section 1201 of the ACA

provisions will tend to lower premiums for older employees and smaller groups, while increasing premiums for younger employees — especially younger males — and larger small groups. Based on the carrier responses, we are assessing the expected effect the new rating rules will have on small group premiums.

Third, new minimum benefit and coverage requirements will tend to put upward pressure on small group premiums.[24] The CBO estimates that premiums in the nationwide small group market will increase by as much as 3% in 2016 as a result of required increases in benefits. Finally, new fees prescribed in the ACA will place upward pressure on premiums if passed along to policyholders. These fees, which we briefly identified at the start of the section, have several forms, but they include the following:

- Annual fees levied on health insurers[25]
- Temporary fees on all health insurance issuers and third-party administrators of group health plans for reinsurance in the individual market[26]
- Fees assessed against pharmaceutical manufacturers[27]
- An excise tax on medical devices [28]

Starting in 2014, the ACA requires that insurers must adopt an adjusted community rating approach as described above. This requirement will limit how carriers can reflect risk differences when setting premium rates. The effect that this new restriction has on premiums will depend upon the degree to which Hawai'i's small group carriers currently employ these measures. Hawai'i has historically afforded its carriers flexibility in how they rate groups and vary premiums based on age, gender, geography, industry, group size and morbidity.

In the forthcoming analysis supported by Oliver Wyman's micro-simulation model, we will recognize the effect of these new rating restrictions in our aggregate summaries.

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[24] Section 1302(a) of the ACA

[25] Section 9010 of the ACA

[26] Section 1341(b)(3)(B) of the ACA

[27] Section 9008 of the ACA

[28] Section 9009 of the ACA

6

Hawai'i's Individual Direct Purchase Market

In Section 6, we take a closer look at Hawai'i's Direct Purchase (or individual) market, examining various characteristics of its carriers and members. In particular, we segment the population based on the prevalence of insurance coverage by age, income, average insurance premiums and certain benefit characteristics. Finally, as in the section on ESI, we present a summary of carriers currently offering coverage in the Direct Purchase market; we show their current market share and premium levels. We also present a summary of benefit plans and some rating practices currently used to develop rates in the individual market, along with an initial, high level impression of the potential effect that rate compression required under the ACA may have on premiums.

Individual Incentives

Of the provisions introduced by the ACA, the Direct Purchase market may see more changes than any other market. The ACA establishes new rating requirements for insurers, new fees for insurers and ancillary providers, tax credits to purchase coverage in the Connector for certain low-income individuals, expanded funding of Medicaid, and various other characteristics. In this section, we will provide a discussion of the market's demographics and new rating requirements for insurers; however, many of these other topics are either covered in more depth in other sections or they are less likely to affect enrollee behavior in this market than in other markets.

Demographics

We are principally concerned with four populations in this background research report: the ESI, Direct Purchase, Medicaid and uninsured. The Direct Purchase population is the smallest of these four. As we present exhibits from the 2010 ACS data, it is important that the reader be aware that, although the market size estimate is credible in total, some estimates of the segmented population may lack credibility due to the small size of this particular market.

The Direct Purchase market has the following age and gender distribution.

Table 6.1
Direct Purchase Enrollment Rates

	Hawai'i		Nationwide	
Age Band	Male	Female	Male	Female
0 to 17	11.5%	9.8%	11.6%	10.9%
18 to 24	0.5%	0.8%	7.9%	7.7%
25 to 29	2.2%	2.7%	4.0%	3.6%
30 to 34	4.2%	4.4%	2.9%	2.8%
35 to 39	3.9%	2.5%	3.0%	2.9%
40 to 44	3.1%	3.6%	3.3%	3.4%
45 to 49	3.7%	5.8%	4.0%	4.1%
50 to 54	5.4%	5.6%	4.3%	4.4%
55 to 59	6.8%	7.2%	4.1%	4.8%
60 to 64	7.3%	8.1%	4.1%	5.5%
65+	0.0%	0.9%	0.3%	0.4%
Total	48.6%	51.4%	49.5%	50.5%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The ACS data show that Hawai'i's Direct Purchase market is generally consistent with the Direct Purchase market for the rest of the country. We note a distinctly lower percentage of Direct Purchase members in the 18 to 24 range in Hawai'i than in the rest of the country. We also note a higher percentage of Direct Purchase members in the 50 to 64 range in Hawai'i than in the rest of the country. We often see that early retirees will either go without insurance or purchase coverage directly. Based on the distribution above, it appears that early retirees in Hawai'i may seek out individual policies at a higher rate than we see for that population in the rest of the country.

The ACS data show that participants in the Direct Purchase market have the following income levels.

Table 6.2
Direct Purchase (in 1,000's)

	Hawai'i	
FPL	Persons	Percentage
201% to 300%	7	15.6%
301% to 400%	9	20.7%
401% +	28	63.7%

2010 American Community Survey – Person Level Data,
http://www2.census.gov/acs2010_1yr/pums/

(As mentioned in the Data section, we have assumed that anyone in the ACS data identified as a direct purchaser and with income below 200% FPL is better classified as a Medicaid enrollee.) The table shows that the majority of Direct Purchase enrollees have incomes above 400% FPL. These higher income members will not have access to tax credits through the Connector, and they could see their premiums increase as a result of required benefit increases, participation of new policyholders in the individual market and a new insurer tax beginning in 2014. In addition, rate compression from both the elimination of gender rating as well as new age rating restrictions (i.e., no more than a 3:1 difference in rates by age) could lead to additional increases in rates for certain demographic cells, essentially amplifying the increase. Some of these members may question the value of their health coverage relative to its cost, and simply choose to go without coverage and pay the individual penalty. Please note that the individual penalty for these higher earners will increase with their income; so, forgoing coverage may be less desirable as the penalties increase. Also, the new rating restrictions may make premiums more attractive for certain members, drawing in new participants to the Direct Purchase market.

Rate Development in the Individual Direct Purchase Market

Beginning in 2011, carriers were required to meet new minimum loss ratio requirements. To support examination of these requirements, the Statutory Financial Statements include a new Supplemental Health Care Exhibit. As such, we are now able to provide certain summary measures by line of business. The following table summarizes the Direct Purchase market in 2011, using information from these publicly available financial statements.

Table 6.3
Hawai'i - 2011 Direct Purchase Experience

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	199,000	260.71	226.96	87%
Kaiser Foundation Health Plan Inc	176,000	221.75	208.74	94%
Total	375,000	$242.43	$218.41	90%
Average	31,250			

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table above shows that roughly 31,250 residents were covered under an individual policy at any point in time in 2011. Over the course of the year, individuals will obtain or drop coverage; so, these were not necessarily the same 31,250 people each month.

From the ACS data, we estimated that roughly 44,000 individuals reported having Direct Purchase coverage. There are several potential reasons for the inconsistency. For example, the underlying level or type of coverage may be a source of the difference. The figures in the table above are from the Supplemental Health Care Exhibit, and they represent comprehensive health coverage. The ACS asks respondents if they have "insurance purchased directly from an insurance company by this person or another family member." Therefore, someone with a hospital indemnity or other limited benefit policy may appear in the ACS data as having Direct

Purchase coverage depending upon how they interpret the question. In addition, a person with COBRA coverage might respond that they have purchased coverage directly from an insurance company; in such a case, the carrier would report that person under a group line of business.

The entire market for individual policies is occupied by two carriers, Hawai'i Medical Services Association (HMSA) and Kaiser Foundation Health Plan, Inc. (Kaiser). And between these two carriers, the market is split relatively evenly. The combined loss ratio for the two carriers is 90%, which is higher than we would expect in the individual market. To provide the reader a basis for comparison, the new minimum loss ratio requirements under the ACA prescribe a loss ratio of no more than 80% for individual lines of business. This prescribed minimum includes a number of offsets for taxes, quality improvement initiatives, etc; it also includes a credibility adjustment. Given the size of the market, these adjustments would likely enable traditional loss ratios that are closer to 75%. Furthermore, the 2011 loss ratio for these two carriers appears to be characteristic of their experience rather than an anomaly for the one year. In 2010, the aggregate loss ratio for individual lines of business was 92%.

The table also shows that in 2011 the average monthly premium for the two carriers was $242 per member per month (PMPM). The average premium in the table above is lower than the average premium of $299 PMPM that we observed in the small group market (Table 5.9 in the previous section). There are a number of reasons why we would expect this difference. For example, the PHCA requires a minimum level of coverage for group employees, while there is no such restriction in the individual market. Also, coverage in the small group market is sold on a guarantee issue basis, as required by Federal law. Carriers in the individual market are allowed to medically underwrite and reject individuals for coverage entirely on the basis of medical conditions. This capability to decline coverage to high risk individuals will lead to a healthier population in the individual lines of business and consequently to lower premiums.

In 2014, the ACA will prohibit insurers from denying individual coverage on the basis of pre-existing conditions.[29] The ACA will prohibit rating based on gender while also imposing new age rating restrictions. The new requirements will generally lead to increased rates for the young, for males in some age ranges, and for the healthy; they will also likely lower rates for the elderly, for females in some age ranges, and for the unhealthy. Carriers will see new limitations on their ability to reflect risk differences when setting premium rates.

As mentioned in the Data section, Oliver Wyman issued a carrier data request in which we asked each carrier to provide distributions of their enrollees by line of business. We also asked that they provide information about current rating practices. Because there are only two carriers in the market, we cannot discuss specific rating practices or enrollment characteristics from the Oliver Wyman data request without openly presenting the response data for each carrier.

[29] Section 1201 of the ACA

On the previous page, we presented average premiums offered in Hawai'i for the 2011 plan year. In addition, we have looked at each carrier's public website, and we can briefly discuss information provided there. Please note that the descriptions below are based on information **currently** available on each carrier's website. The information may not correspond with what was in place for 2010 or 2011 or what will be in place in future years.

Benefit Offerings in the Direct Purchase Market

As discussed in a previous section, the ACA requires that individuals obtain minimum essential coverage for themselves and their dependents beginning in 2014. We also discussed that the purchase of a QHP in the individual market would satisfy this requirement, thus avoiding a tax penalty.

Although HMSA offers various products that they classify as providing individual coverage (e.g., student, conversion, etc.), our review focuses on those plans identified as Individual Care Plans or the Catastrophic Care Plan. Under these plan types, HMSA offers a total of three benefit designs. Under Individual Care Plan type, HMSA offers the high option design and basic option design, and both plans are HMOs. Under the Catastrophic Care Plan, HMSA offers one design, a PPO.

Similarly, Kaiser's website presented three primary plan types. Two of the plans are more comprehensive, provide network coverage only, and have copays for most of their cost sharing provisions. The third plan provides limited coverage, only focusing on facility-based services.

The following table summarizes the single deductible, out-of-pocket (OOP) maximum, office visit cost sharing and inpatient cost sharing of these plans:

Table 6.4

	Single Deductible	Office Visit	Inpatient Visit	OOP Maximum
HMSA				
ICP High Option	$300	$20	10%	$5,000
ICP Basic Option	$500	$20	30%	$7,500
Catastrophic	$2,500	$20	20%	$3,500
Kaiser				
KP 20/Rx	$0	$20	$150 per Day	$2,500
KP 30/RX	$0	$30	$450 per Day	$4,000
KP Basic	$0	NC	$500 per Day	$5,000

http://www.hmsa.com/healthplans/individual/icp/default.aspx

http://www.hmsa.com/healthplans/individual/ccp/default.aspx

https://kaiser.healthinsurance-asp.com/expressweb/plan/AvailablePlans.action?groupId=0&quoteId=0#

The Kaiser KP Basic plan provides almost no coverage for outpatient services, while the remaining plans are generally consistent in what they cover. However, the cost sharing can vary substantially between each plan. It is also worth noting that the HMSA catastrophic plan is a PPO while the other two HMSA and Kaiser plans are HMOs.

Coverage Tier, Age/Gender, and Health Status

Based on information from each carrier's website, we were able to glean some information about current rating practices. For the three HMSA plans, rates are offered for three tiers: individual, two party, and family, and these tiers are rated over three age ranges: 0 to 24, 25 to 49, and 50+. Based on information from HMSA's website, the tier and plan relativities for the individual plans have the following form:

	Tier		
Age	Individual	Two Party	Family
0-24	0.68	1.36	2.04
25-49	1.00	2.00	3.00
50+	1.36	2.72	4.08

The 2012 rates presented on HMSA's website for the three plans in question do not show variations in age rating above the 3 to 1 differential prescribed by the ACA. As a consequence, we do not expect HMSA enrollees to see rate shock from the new rating requirements.

In rating its individual plans, Kaiser employs member-level rating. That is, each member in a household is assigned a unique rate rather than rates being reflective of the average family composition for Kaiser's individual line of business. Kaiser does vary their rates for these products by gender. At the time of this review, they also varied their age rates for males over the 3 to 1 differential prescribed by the ACA (3.12 between ages 64 to 18). Kaiser's individual rate differential for females was 2.7 to 1 for the same ages (i.e., 64 to 18).

Neither carrier explicitly specified that they do not rate by health status on their websites. However, both do provide explicit quotes and indicate that eligibility is subject to medical underwriting. These quotes would seem to imply that, rather than being used for rate setting, underwriting is only used to determine whether or not the carriers will make an offer of coverage.

7

Hawai'i's Low-income Market

Hawai'i's Med-QUEST Division (through the DHS) and the Federal government spent $1.7 billion in fiscal year (FY) 2011 on providing a robust health care safety net for its low-income residents.[30] Along with the presence of the PHCA, these efforts have helped to keep Hawai'i's uninsured population below the national average. Provisions within the ACA will help ease some of the budgetary pressure on the State (on a per member basis).

Hawai'i provides public coverage to low-income individuals through several managed care programs. Although some low-income enrollees are in fee-for-service (FFS), most are in managed care. The majority of Medicaid enrollees are children, new or expecting mothers, and qualifying families with children. In addition to these enrollees, the medically needy, non-citizens and aged, blind and disabled (ABD) individuals that receive SSI may qualify. Hawai'i's criteria for eligibility include Hawai'i residency status and income and asset tests. However, the asset tests will no longer apply under the ACA.

The primary Med-QUEST programs are the following:

QUEST – This program provides coverage to individuals under age 65 who are not blind or disabled with an emphasis on children and their parents. The program is administered through participating managed care organizations, with income eligibility requirements at various ages (e.g., pregnant mothers qualify for coverage with an income up to 185% of FPL). The emphasis of the program is on primary and acute care.

QUEST Expanded Access – This program covers those that qualify for Medicaid because they are 65 or older, blind, or disabled. As with QUEST, the program is administered through participating managed care organizations, with coverage provided for primary and acute care as well as long-term care services. The program emphasizes home and community based care, and many of these enrollees were covered under FFS until 2009.

QUEST Adult Coverage Expansion (or QUEST-ACE) – Through June 2012, this program provided limited health care benefits to adult beneficiaries; to be eligible, an individual must have been 19 years or older and have had household income less than 200% of FPL. In July 2012, the program was revised to cover a more comprehensive set of benefits, but eligibility was restricted so that the program only covers those with household income less than or equal to 133% of FPL. Under QUEST-ACE, an individual is eligible without having been enrolled in

[30] *http://hawaii.gov/dhs/main/reports/AnnualReports*

another Med-QUEST program (e.g., QUEST or QUEST Expanded Access), and the individual must not have additional coverage from an independent source.

QUEST-Net – As with QUEST-ACE, the QUEST-Net program offers childless adult beneficiaries limited health care benefits, and through June 2012, it restricted eligibility to those with household income below 200% of FPL. In July 2012, the program was expanded to cover a more comprehensive set of benefits, but eligibility was restricted to those with household income less than or equal to 133% of FPL. Unlike QUEST-ACE, beneficiaries in QUEST-Net must have been enrolled in the QUEST, QUEST Expanded Access or FFS programs and subsequently lost coverage due to increased income, assets, or other disqualifying reasons.

S-CHIP – This program was implemented as a Medicaid expansion program in Hawai'i, and although we identify it as a unique program here, it is a sub-program of the QUEST Expanded Access (for blind and disabled children) and QUEST programs. To qualify for coverage, children must be uninsured, under age 19, and have family incomes not exceeding 300% of the FPL. Please note that Hawai'i does not maintain a separate program for Compact of Free Association (COFA) children. The Federal CHIP Reauthorization Act of 2009 permitted COFA children to become eligible under S-CHIP. COFA and immigrant children are now covered under Hawai'i's Medicaid expansion CHIP program, and Hawai'i receives Federal matching funds for medical assistance provided to them.

Transitional Medical Assistance – Aid to Families with Dependent Children (AFDC) is the predecessor to the TANF program; anyone eligible for AFDC was automatically eligible for Medicaid. Although there are a number of eligibility requirements, an AFDC recipient who has lost eligibility due to increased earnings or work hours, is entitled to Transitional Medicaid for up to 12 months (subject to the other eligibility requirements).

In addition, Hawai'i has some low-income residents that are dually eligible for Medicare and Medicaid whose services are reimbursed on a FFS basis.

The following table shows the distribution of enrollees by program.

Table 7.1

Program	Enrollment
Quest	64.1%
S-CHIP	9.7%
Quest Expanded Access	15.6%
Quest-ACE	5.0%
Quest-Net	0.3%
Transitional Medical Assistance	2.3%
Other	3.0%
Total	100.0%

http://www.med-quest.us/PDFs/queststatistics/2012%20QUEST%20ENROLLMENT.PDF

As the table shows, most of Hawai'i's Medicaid enrollees are in some form of managed care. Hawai'i currently contracts with five of these managed care plans. Three plans support QUEST enrollment, and they are the following:

- Hawai'i Medical Services Association (HMSA) is the Blue Cross Blue Shield plan of Hawai'i
- AlohaCare is a local non-profit plan that was founded by Hawai'i's Community Health Centers
- Kaiser Foundation Health Plan is a not-for profit health plan and part of the Kaiser Permanente managed care consortium

Two additional plans support enrollment in QUEST Expanded Access, and they are the following:

- Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc.
- Evercare is offered by UnitedHealthcare Insurance Company

In 2012, enrollees in these five plans were distributed in the following fashion.

Table 7.2

Plan	Distribution
Quest	
HMSA	45.0%
AlohaCare	29.1%
Kaiser	10.0%
Quest ExA	
Ohana	8.5%
EverCare	7.4%

http://www.med-quest.us/PDFs/queststatistics/2012%20QUEST%20ENROLLMENT.PDF

Please note that in July 2012, United and Ohana were awarded Quest contracts, bringing the total number of carriers to five. In the Data section, we speculated that the Med-QUEST Division's reports may reflect the upper limit of Medicaid enrollment. Medicaid enrollees in households with enrolled children are passively re-enrolled. This dynamic makes it more difficult to assess how many individuals are covered by Hawai'i's Medicaid program at any one point in time.

As we review the population estimates that result from the ACS survey data, we note that the total Medicaid enrollees identified from the survey are fewer than the enrollment identified by the Med-QUEST. There are several possible sources for the inconsistency. First, as noted in previous sections, the US Census Bureau attempts to correct for a systematic bias of underreported Medicaid participation in the ACS data (e.g., because members believe they have private coverage). Despite these efforts, the US Census Bureau may not have fully accounted

for all publicly financed health coverage, especially those with coverage through QUEST-Net or QUEST-ACE. Second, there are enrollees in the Medicaid program who are not United States citizens; it is not clear that the ACS have adequately accounted for these individuals in their methods.[31]

The ACS data are from surveys conducted in Hawai'i during 2010.[32] Since then, we know that the overall enrollment in Hawai'i's public programs has increased by at least 13%.[33] The following table shows the demographic composition of those enrolled in Hawai'i's Medicaid program in 2010 as identified by the ACS data.

Table 7.3
Medicaid Enrollment Rates

	Hawai'i		Nationwide	
Age Band	Male	Female	Male	Female
0 to 17	19.9%	19.5%	25.2%	24.1%
18 to 24	5.4%	8.1%	3.1%	4.8%
25 to 29	2.4%	3.4%	1.6%	3.1%
30 to 34	1.7%	2.6%	1.6%	2.6%
35 to 39	1.3%	1.9%	1.5%	2.4%
40 to 44	2.2%	2.5%	1.7%	2.1%
45 to 49	2.3%	2.0%	1.8%	2.1%
50 to 54	2.3%	2.8%	1.7%	2.0%
55 to 59	1.7%	2.3%	1.5%	1.8%
60 to 64	1.5%	2.0%	1.3%	1.7%
65+	4.8%	7.6%	4.3%	7.8%
Total	45.4%	54.6%	45.4%	54.6%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, the demographic composition of Hawai'i's Medicaid enrollees is, in total, consistent with the rest of the country. The primary difference is that Hawai'i's Medicaid enrollment is older, on average, than the nation's Medicaid enrollment. Because of Hawai'i's initiatives to cover low-income childless adults through QUEST-ACE and QUEST-Net, we would expect a distribution weighted towards older ages. It is worth noting that the ACS data are slightly skewed toward older age groups relative to some DHS reports.[34]

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[31] *DHS informed OW in an August 1, 2012 phone call that Medicaid covered between 10,000 and 12,000 COFA individuals, while the ACS reflects only 5,000.*

[32] *We do not expect results from 2011 ACS to be available until September 2012 or October 2012.*

[33] *http://www.med-quest.us/ManagedCare/MQDquestenroll.html*

[34] *http://hawaii.gov/dhs/quicklinks/MQD%20presentation%2004_03_2012.pdf*

Beginning in January 1, 2014, the ACA will increase Medicaid funding for states providing coverage to childless adults. For expansion states (i.e., states already providing coverage for childless adults), the new Federal Medical Assistance Percentage (FMAP) will have the following form for the expansion individuals' costs.

Table 7.4

Year	New FMAPs	Transition Percentage	Regular FMAP	Expansion FMAP*
2014	100%	50%	52%	76%
2015	100%	60%	52%	81%
2016	100%	70%	52%	86%
2017	95%	80%	52%	86%
2018	94%	90%	52%	90%
2019	93%	100%	52%	93%
2020	90%	100%	52%	90%

*Regular FMAP + (Newly eligible FMAP – Regular FMAP) x Transition Percentage

http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

(We present this example assuming that the Federal government will recognize Hawai'i as an expansion state; if the government does not recognize Hawai'i as an expansion state, the example would not hold.) Funding from the Federal government will supplement Hawai'i's costs for the childless adults (under 138% FPL) who are covered under the QUEST-Net and QUEST-ACE programs. These additional funds will take some budgetary pressure off of Hawai'i (on a per member basis).

The following table shows the distribution of Medicaid covered enrollees by household income as identified by the ACS data.

Table 7.5
Medicaid (in 1,000's)

FPL	Hawai'i		Nationwide	
	Persons	Percentage	Persons	Percentage
0 to 100%	84	36.2%	24,930	46.7%
101% to 138%	31	13.2%	7,963	14.9%
139% to 200%	38	16.2%	8,177	15.3%
201% to 300%	31	13.4%	6,205	11.6%
301% to 400%	24	10.5%	2,718	5.1%
401% +	24	10.5%	3,364	6.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

According to the table, about 50% of Hawai'i's Medicaid enrollees in 2010 had household incomes above 138% of FPL, while approximately 38% of the rest of the country's Medicaid enrollees are above 138% of FPL.

As the State bears much of the coverage cost for Medicaid enrollees, it is worth examining individuals that are employed and obtain coverage through the Med-QUEST Division. This is particularly important because employees have the option to waive coverage mandated under the PHCA if they are covered by a federally established health insurance program such as Medicare or Medicaid.[35] The following table shows the distribution of employees with or without Medicaid by industry.

Table 7.6
Employee Distribution - Private Industry in Hawai'i

Industry	Medicaid	All Others
Agr, Mining, Util	2%	3%
Const & Manu	5%	14%
Trade	26%	17%
Transp, Info, Finan	12%	11%
Real Estate	5%	4%
Prof, Sci, Tech	4%	5%
Mang, Admin Srv	5%	6%
Education	7%	4%
Health & Soc Srv	5%	12%
Arts, Ent, Food, Other	29%	24%
Public Admin	0%	0%

2010 American Community Survey – Person Level Data,
http://www2.census.gov/acs2010_1yr/pums/

The table shows that employees in trade (retail and wholesale) and the arts, entertainment, and food services make-up over half of the privately employed individuals on Medicaid. The table also shows the there is a lower proportion of Medicaid-covered individuals in construction and manufacturing as well as in health and social services. We suspect that construction and manufacturing jobs are more likely to be occupied by men than women, and men are less likely to be eligible for Medicaid. We also suspect that employees and employers in health and social services will better understand their health insurance options and requirements than those in other services.

[35] *http://hawaii.gov/labor/dcd/aboutphc.shtml*

8

Hawai'i's Uninsured Population

Because one of the central goals of the ACA is to lower the number of uninsured, we devote this section of the report to examining characteristics of uninsured individuals residing in Hawai'i.

The ACA includes financial incentives designed to encourage individuals who can afford health insurance to obtain at least some minimally comprehensive level of coverage.[35] These incentives exist both as additional taxes for those that do not obtain coverage as well as tax credits for certain qualified individuals that do. The ACA also provides funding to states to ease the eligibility requirements for Medicaid. Because Hawai'i already funds expanded Medicaid programs to cover low-income adults, these initiatives may not change the number of uninsured as much as they are expected to change them in other states without expanded Medicaid coverage. For states that implement the expansion for newly eligible persons, the Federal government will provide payment at 100% of program costs for these new enrollees between 2014 and 2016. After the first two years, this FMAP percentage will decrease to 90% by 2020. As we understand it, Hawai'i already provides coverage for these people and will not receive the 100% reimbursement for them in 2014. Rather, as an expansion state, Hawai'i will receive approximately 75% of funding in 2014, with the FMAP increasing to 90% by 2020.

Uninsured Purchase Decision

The ACA's individual mandate imposes a tax on those individuals who do not maintain coverage. The mandate is not universal and provides a tax exemption for certain low-income individuals who cannot afford coverage. The tax is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015 and 2.5% in 2016). Ultimately, the tax reflects the larger of these two possible payments; however, it is capped at the national average premium for Bronze coverage.[37] Returning to our example from an earlier section, a single uninsured individual earning $25,000 per year (or approximately 220% of FPL in 2010) would incur a tax equal to that listed in the following table.

[36] *Certain exemptions apply to individuals who either cannot afford insurance or are not permitted due to religious beliefs. The ACA defines individuals who cannot "afford health insurance" as those for whom the minimum policy will cost more than 8% of their monthly income, and whose income is greater than 100% FPL.*

[37] *Children are only assessed at one half the flat amount, and there is cap for families.*

Table 8.1
ACA Individual Mandate Example

	2014	2015	2016
Income*	$25,000	$25,000	$25,000
Flat Tax Amount	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Tax	$250	$500	$695

*Assumes no wage inflation and that the national average bronze premium is less than the resulting penalty

The Health Care and Education Reconciliation Act, Subtitle A, Section 1002

Also as discussed in an earlier section, the ACA provides tax credits to eligible individuals and families with incomes up to 400% FPL for the purchase of a QHP through the Hawai'i Connector. The government will ultimately determine the credits based on both the premium for the second lowest cost Silver plan in the Connector as well as how that premium cost relates to an individual's household income. Or put differently, two individuals with the same income will get the same credit based on that income level and second lowest cost Silver plan in the Connector; the actual plan they elect has no effect on their subsidy. The premium for any taxpayer whose household income is within a given income tier will be restricted to the percent of income as identified in the following table. Within each income range, those percentages will increase (on a sliding scale in a linear manner) from the initial premium percentage to the final premium percentage.

Table 8.2

Household Income	Initial Premium Percentage	Final Premium Percentage
Up to 133%	2.00%	2.00%
133% to 150%	3.00%	4.00%
150% to 200%	4.00%	6.30%
200% to 250%	6.30%	8.05%
250% to 300%	8.05%	9.50%
300% to 400%	9.50%	9.50%

The Health Care and Education Reconciliation Act, Subtitle A, Section 1001

Subsidy-eligible individuals are not obligated to participate in the second lowest cost Silver plan. They may participate in a plan with additional benefits or lower cost sharing, but the premium tax credit will be calculated relative to that Silver plan's premium. Likewise, they may elect to purchase a plan with higher cost sharing (i.e., a Bronze plan) and receive the same premium tax credit. For the lowest income individuals, tax credits would likely cover the entire premium for coverage under a Bronze plan.

Individuals with incomes below 250% of FPL may also be eligible for cost-sharing subsidies; however, these individuals must enroll in a Silver plan to receive the subsidies. As a consequence, there is rarely an incentive for individuals with incomes below 250% of FPL to pay the additional premium for a Gold or Platinum plan. (Under such a scenario, the individual would effectively be left with a higher cost sharing burden than if they enrolled in a Silver plan and received the cost sharing subsidy.) However, the effect for these qualified individuals that use their premium subsidies to purchase a Bronze plan instead is significant; they would likely eliminate any up-front premiums. We suspect that they are less affected by the possibility of incurring bad debt and will place more importance on elimination of the premium. This dynamic may be particularly true for low-income individuals in good health who expect to incur little to no medical expenses.

If we extend the example given above, our theoretical person with an income equal to $25,000 in 2014 would face the following incentives in assessing whether or not to purchase coverage. First, they would face a penalty of $250 for not obtaining coverage. Second, they would be eligible for a tax credit. Assuming this person is a single individual, the premium for the second lowest cost Silver plan in Hawai'i is equal to $430 PMPM, and the FPL is calculated from the 2010 basis, the person would be eligible for the following credit.

Sample FPL	Income	Plan Cap %	Plan Cap $	Plan Cost	Tax Credit
220%	$25,000	7.0%	$1,750	$5,160	$3,410

The incentives for the person would be the following:

Purchase Coverage	Do Not Purchase Coverage
Plan Cost — $5,160	Tax — $250
Tax Credit — $3,410	
Realized Cost — $1,750	

** Subject to the theoretical assumptions identified above*

In this theoretical example, the marginal gross cost of purchasing insurance is $1,500 (= $1,750 - $250) (assuming the FPL from 2010). A key question becomes "what is the likelihood that this person values health insurance coverage at more than $1,500?"

However, this information alone is not enough to model the individual purchasing decision, because individuals also place value on having health insurance. In the report outlining our model approach, we will introduce the concept of utility. As we model the universe of purchasing decisions available to each individual, we will examine the marginal cost of purchasing insurance (as identified above); we also model the health status and expected benefit costs for each person. In our example, a healthy person with low expected claim costs and $1,500 in marginal insurance costs will be less likely to purchase coverage than an unhealthy person with the same expected marginal insurance costs. Or put differently, coverage is worth more to an unhealthy person, and they will be more likely to purchase it.

Population Characteristics

As with many other states, Hawai'i currently covers low-income individuals that qualify for coverage through traditional Medicaid or CHIP eligibility requirements. As discussed in the previous section, Hawai'i also has the QUEST-Net and QUEST-ACE programs in place. These programs cover certain low-income adults that would not meet Medicaid's traditional eligibility requirements in other states.

With a much larger part of the population residing in Oahu, we would expect the distribution of uninsured residents to be higher there as well. The following table shows that distribution by island grouping.

Table 8.5
Uninsured (in 1,000's)

	Uninsured		Total Population	
Island Group	Persons	Percentage	Persons	Percentage
Oahu	58	56.0%	956	70.1%
Hawaii	20	19.0%	185	13.6%
Kauai, Maui, Molokai	26	25.1%	222	16.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Although the majority of uninsured residents do live in Oahu, the proportion of uninsureds in Hawai'i's most populous island is substantially different than the general population. Over 70% of residents make their home in Oahu, but Oahu has only 56% of the uninsured. Please note that the ACS does not group Hawai'i's population by island, rather it groups them to achieve population clusters of a certain size. As such, we have not provided island-by-island detail beyond what you see here. However, the resulting distribution is consistent with estimates prepared from the Behavioral Risk Factor Surveillance System Survey.

There are several possible causes for this difference in uninsured rates by island grouping. As we presented it in the Private Employer Market section, a larger portion of real estate and agricultural workers work outside of Oahu. Because the PHCA does not enforce the same level of coverage requirements on employers in agriculture or commission based real estate ventures, the higher uninsured rate in the surrounding islands is directionally consistent with the predominant industries. As the State works to allocate resources in support of the Connector (and potentially the BHP), these geographic dynamics will be an important part of its planning process.

The following table shows the distribution of the uninsured by age and gender, based on data from the ACS.

Table 8.6
Uninsured Rates

	Hawai'i		Nationwide	
Age Band	Male	Female	Male	Female
0 to 17	5.6%	5.1%	6.2%	5.9%
18 to 24	9.1%	7.2%	10.8%	7.9%
25 to 29	8.5%	5.1%	7.9%	5.4%
30 to 34	4.2%	3.1%	6.3%	4.4%
35 to 39	4.6%	3.8%	5.5%	4.1%
40 to 44	5.8%	3.1%	5.0%	4.0%
45 to 49	4.5%	3.7%	4.8%	4.0%
50 to 54	6.6%	3.6%	4.0%	3.6%
55 to 59	3.3%	2.3%	2.8%	2.7%
60 to 64	4.1%	3.0%	1.8%	2.2%
65+	1.8%	1.8%	0.4%	0.5%
Total	58.2%	41.8%	55.3%	44.7%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Hawai'i appears to have a lower percentage of uninsured females than the rest of the country. This gender disparity may result if Hawai'i is more effective in enrolling Medicaid eligible individuals into its program than are most states.[38] Variation in Medicaid programs across states may serve to obscure the cause of any underlying differences. The distribution in the preceding table also permits the reader to observe additional volatility in the Hawai'i sample. The nationwide distribution decreases uniformly from the 18 to 24 age band, while the Hawai'i distribution shows increases at some older age bands. This volatility likely results from the smaller sample size for Hawai'i.

Because of the potential for tax credits for low-income residents, we also consider the income of those without coverage. The following table identifies the 2010 income levels for those who are uninsured.

[38] *http://www.shadac.org/files/shadac-access-profile-jan11.pdf*

Table 8.7
Uninsured (in 1,000's)

	Hawai'i		Nationwide	
FPL	Persons	Percentage	Persons	Percentage
0 to 100%	26	25.4%	14,870	30.8%
101% to 138%	9	8.5%	6,160	12.8%
139% to 200%	12	11.4%	8,326	17.3%
201% to 300%	20	19.0%	8,735	18.1%
301% to 400%	11	10.2%	4,582	9.5%
401% +	26	25.5%	5,583	11.6%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the data in the table show, Hawai'i has a far larger percentage of uninsured that are above 400% of FPL than the rest of the nation. Correspondingly, there is a lower percentage of uninsured below 200% FPL. There are several questions that arise from these distributions. First, what are the characteristics of these residents earning more than 400% of FPL and what drives their decision not to purchase insurance? And second, why are there individuals who would seem to be eligible for coverage under Hawai'i's expanded Medicaid programs, but remain uninsured? We suspect that the percentage of uninsureds above 400% of FPL seem higher only because Hawai'i is better at providing coverage to its low-income population through its expanded Medicaid than is the rest of the country. (We have seen these dynamics in other states with expanded Medicaid programs.)

Often, we see a demographic group referred to as 'young invincibles' in this uninsured cohort where income is above 400% of FPL. These young invincibles are typically between the ages of 18 and 34. They also choose not to purchase coverage (though they may have the financial means) because they are relatively healthy and weigh the coverage cost as worth more than the coverage. If we first examine the uninsured by income and age for the nation, the ACS data show the following:

Table 8.8
Nationwide Uninsured

	FPL		
Age Band	0% to 200%	201% to 400%	400%+
0 to 17	8.0%	3.2%	0.9%
18 to 34	26.1%	11.6%	5.1%
35 to 64	26.3%	12.6%	5.5%
65+	0.5%	0.2%	0.1%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the distribution of the uninsured across the various age and income categories (i.e., the sum of the cells should equal 1.00; it differs by 0.001 because of rounding). From the table, we see that generally the uninsured at all income levels are evenly split between 18 to 34

year-olds and 35 to 64 year-olds. Please note that 35 to 64 year-olds have about 71% more people in the total population; so for those above 400% of FPL, the uninsured rate is higher among the 18 to 34 year-olds than it is among the 35 to 64 year-olds. If we now examine the uninsured by income and age for Hawai'i, the ACS data show the following:

Table 8.9
Hawai'i Uninsured

	FPL		
Age Band	0% to 200%	201% to 400%	400%+
0 to 17	5.7%	3.4%	1.6%
18 to 34	17.5%	10.4%	9.3%
35 to 64	21.1%	14.1%	13.3%
65+	1.0%	1.4%	1.2%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows that young invincibles with income above 400% of FPL may be a larger percentage of the uninsured in Hawai'i than what we see in the rest of the country (9.3% versus 5.1%). However, the percentage of uninsured at each income level is weighted more towards those between the ages of 35 and 64 than it is towards those between the ages of 18 and 34. It appears that Hawai'i's large percentage of uninsureds above 400% of FPL is not the result of a large young invincibles population.

The ACS data also show that there are a number of uninsured adults with incomes below 200% of FPL. It seems that some of these individuals would have qualified for coverage under Hawai'i's QUEST-Net or QUEST-ACE programs in 2010. Returning to the table on a previous page, approximately 45% of those without coverage are below 200% of FPL. It is unclear why persons who would seem to be eligible for one of Hawai'i's Medicaid expansion programs would remain without coverage. These individuals may have met the State's income requirements for eligibility but not the asset requirements. Perhaps these individuals feel there is a stigma attached to publicly sponsored coverage. Perhaps they are healthy and unaware of the program, or perhaps there is some other unknown dynamic. In 2003, the Robert Wood Johnson Foundation funded a public survey of the uninsured in Hawai'i.[39] According to that analysis, only 37% of the uninsured respondents had investigated ways to obtain health insurance. Modeling the behavior of these individuals and how they might respond to the incentives in ACA will be a challenge.

Effective September 2010, insurers were required to offer coverage for dependents under the age of 26.This requirement differs for grandfathered and non-grandfathered plans.[40] Based on

[39] *http://www.healthcoveragehawaii.org/research/generalpublicsurvey.html*

[40] *For grandfathered policies until 2014, coverage is only required to be extended to dependent children to age 26 if the dependent child does not have another offer of employer-sponsored health coverage.*

estimates published in the Congressional Research Service,[41] we estimate that this provision of the ACA could affect between 1% and 3% of the uninsured population. We will recognize the effect of these changes when we project the population in the future modeling portion of the project.

[41] *Chaikind and Fernandez, "Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service (2011).*

9

Basic Health Program

With the State's expanded Medicaid program and the introduction of tax credits for some low-income participants in the Connector, provisions of the ACA are expected to stabilize coverage for the low-income population. In this section, we discuss the BHP option and how it will support these provisions, we introduce some of its requirements, and we address how it might affect Hawai'i's low-income residents.

Tax credits (through the purchase of insurance in the Connector) are the ACA's primary approach to compel non-Medicaid eligible individuals to maintain coverage when their income is less than 200% of FPL. However, there is evidence that a significant portion of the population under 200% of FPL will gain or lose Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. If implemented, states will be permitted to offer a BHP to non-Medicaid individuals that meet the following criteria:

- They are not eligible for Medicaid or CHIP
- They are under 65 years old at the beginning of the plan year and not eligible for Medicare, or TRICARE, or Veteran's Health Care
- Their income falls between 133%[42] and 200% FPL for US citizens and between 0% and 200% FPL for lawfully present immigrants.
- If they have access to ESI coverage, it does not provide coverage for essential benefits or is deemed unaffordable based on their income

Within the BHP, states contract with health plans to provide essential health benefits for these non-Medicaid eligible low-income individuals. However, there are numerous requirements for participating plans, including the following:

- The health plans must maintain a minimum medical loss ratio of 85%
- Contracts must be awarded through a competitive bidding process (as much as such an approach is possible)
- Coverage must be coordinated with Medicaid and CHIP
- The plan must provide essential health benefits

If Hawai'i were to contract with a plan under the BHP, the Federal government would provide the State 95% of the premium tax credits and cost-sharing subsidies that would have been provided

[42] *A 5% disregard applies when determining Medicaid eligibility; therefore the effective value is 138%.*

for those individuals had they been enrolled with individual coverage in the Connector. The Federal Government would base Hawai'i's reimbursement not on the cost of the covered enrollees, but rather on the average cost of those covered in the individual market (both inside and outside the Connector). If costs are lower than the Federal Government's tax credit, the BHP would have to offer reduced premiums, reduced cost sharing, higher provider reimbursement, or additional benefits. Also, if no excess funds are available from the Federal Government, the State would have to cover the cost of any additional benefits that are not included in the essential benefits package.

Individuals enrolled in the BHP can only be required to pay premium that is no more than what they would have had to pay for the second lowest cost Silver plan in the Connector (i.e., net of any tax credits). There will be some level of cost-sharing subsidization for BHP participants. For those individuals between 100% and 150% FPL, the State will receive cost-sharing subsidies (funded by the Federal government) so that the member can be required to pay cost sharing that is no more than what they would pay under the equivalent Platinum level benefits. For those individuals with income between 150% and 200% FPL, the State would receive cost-sharing subsidies so that the member can be required to pay cost sharing that is no more than what they would pay under the equivalent Gold level benefits.

If we again look at the ACS data and estimate who might be eligible for the BHP, we find that they have the following distribution:

Table 9.1

Current Coverage Status	Potential BHP Enrollment
ESI	24.2
Medicaid	16.4
Uninsured	9.7

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Please note that we have not included dual eligible enrollees or those that are currently covered under Medicare, as they are not eligible to participate in the BHP. We have also removed anyone that is employed by the government in the ESI estimates; we have also excluded anyone identified as having ESI in the same household where the principal person or their spouse is employed by the government. Finally, the table above does not recognize lawfully present immigrants below 133% of FPL with fewer than five years of residency. These individuals do not qualify for Federal funding under Medicaid, but would qualify for the BHP.

10

Exchange Eligibility Estimates

The strength and viability of Hawai'i's Connector will depend directly on the number of people that use it. In this background research, we have only identified residents that could be affected by the ACA's incentives; we have not considered the likely enrollment in the Connector.

In the following table, we show individuals that could be eligible for subsidies through the Connector; we show these individuals by coverage mode. Some segments of the population will not qualify for credits in the Exchange, however, some of these non-qualifying persons (especially younger individuals) may be more comfortable purchasing coverage online than they would through an agent; we have not explicitly considered this population in the discussion below.

Table 10.1

Current Coverage Status	Persons per Category (1,000's)
Uninsured	
139% to 400%	37.9
401% +	26.5
Direct Purchase	
139% to 400%	16.0
401% +	28.0
ESI	
139% to 400%	189.7
401% +	232.7

2010 American Community Survey – Person Level Data,
http://www2.census.gov/acs2010_1yr/pums/

From the table, there are approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) that would be eligible for subsidies through the Connector. (Please note that these estimates do not include the COFA population; they are currently classified as Medicaid and total approximately 5,000 members based on our estimates.). In presenting these estimates, we are including those with income between 139% and 200% from the above categories, assuming that there is no BHP. If a BHP is implemented, the number of eligible persons we have estimated in the table above would come down. We have also identified workers that might be eligible for coverage through the Exchange. Given the strength of the PHCA, we suspect that there are fewer employers that would drop coverage in Hawai'i than what we anticipate in other states. In addition, the provision of the PHCA that requires employee contributions of no more

than 1.5% of income (for most workers) will disqualify many of the employees for subsidies in the Connector. However, some that are uninsured or that have Direct Purchase coverage and household income above 400% FPL, might purchase insurance through the Connector. If the Connector provides an accessible and transparent view of available products, those individuals may decide that the Connector is the best venue for their purchase.

The segment of the population that creates the greatest uncertainty is the small group employers that could receive coverage through the SHOP Exchange. We have identified approximately 151,000 Hawai'ians enrolled in fully insured small group coverage in 2011.

Participating Carriers

There are numerous considerations that carriers will have to make when deciding whether or not to participate in the Connector. The health insurance market in Hawai'i is dominated by two carriers, and any carrier wishing to participate in the State's Connector is going to explicitly recognize the effect of a potential presence from these two large carriers. Plans considering participation in the Connector will also consider the size of the potential market. As the number of subsidy-eligible people participating in the market increases so will the attractiveness of offering plans in the Connector. Conversely, the presence of a BHP will lower the size of the subsidy-eligible market, and consequently, it may make the market less attractive.

Smaller carriers may be attracted to the Connector because it could lower some of their administrative costs. A cost reduction of this kind would allow them to offer products that are more competitive with the larger plans in the market. Also, the Connector will presumably present smaller carriers' products alongside those products of larger carriers. In addition to showing products from different carriers on an equal footing, the Connector will also allow consumers to compare premiums for plans with like benefits or similar actuarial values. Any marketing advantage the larger carriers have would likely be mitigated on the Connector. Finally, the risk adjustment mechanism will help moderate gains and losses for these smaller carriers, which should help address concerns regarding anti-selection within the Connector.

Lastly, carriers may decide not to participate in the Connector if the market's potential does justify administrative cost and compliance requirements. For example, if Hawai'i were to require that benefit designs in the Connector be at specific actuarial values (e.g., 0.70, 0.80, etc.) rather than ranges, or even small tolerances around these values, carriers may decide that compliance with the requirements is too costly. Also, carriers may decide not to participate in the SHOP because employees are provided flexibility in multi-benefit choice situations (i.e., employees can choose similar metals from different carriers). In the period immediately following implementation, carriers would find it difficult to accurately recognize such anti-selection in pricing. Finally, if the State funds the Connector in part through carrier fees, it would raise carriers' costs and act as another barrier to participation in the Exchange.

APPENDIX A

Estimate of Individuals Covered by Public Coverage

In the following table, we identify the public coverage enrollment implied by the Med-QUEST's program enrollment report. The table shows the raw estimate of enrollment in different insurance modes under ACS. It shows the estimates of enrollment after we have revised the status of many Direct Purchase enrollees. We implemented this revision to more closely match the Direct Purchase enrollment identified by Hawai'i's insurance carriers.

Table A.1
Coverage Summaries (in 1,000's)

	Without Medicaid Edits		With Medicaid Edits	
Coverage	Persons	Distribution	Persons	Distribution
Employer (non-Medicare)	717	52.6%	717	52.6%
Employer (Medicare)	95	7.0%	95	7.0%
Military (Active)	93	6.8%	93	6.8%
Military (Retired)	1	0.1%	1	0.1%
Direct Purchase	72	5.3%	44	3.2%
Medicare	77	5.6%	77	5.6%
Medicaid	165	12.1%	193	14.2%
Dual	39	2.9%	39	2.9%
No Coverage	104	7.6%	104	7.6%
Total	1,363	100.0%	1,363	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the magnitude of the adjustments that Oliver Wyman applied to both the Direct Purchase and Medicaid categories.

APPENDIX B

Hierarchy for Assigning ACS Respondents to a Payer Mode

The following table shows the hierarchy that we used to classify enrollees in the ACS data.

Hawai'i — ACS Category map

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
1	1	1	1	1	1	1	DUAL
1	1	1	1	1	1	2	DUAL
1	1	1	1	1	2	1	DUAL
1	1	1	1	1	2	2	DUAL
1	1	1	1	2	1	1	DUAL
1	1	1	1	2	1	2	DUAL
1	1	1	1	2	2	1	DUAL
1	1	1	1	2	2	2	DUAL
1	1	1	2	1	1	1	ESI_R
1	1	1	2	1	1	2	ESI_R
1	1	1	2	1	2	1	ESI_R
1	1	1	2	1	2	2	ESI_R
1	1	1	2	2	1	1	ESI_R
1	1	1	2	2	1	2	ESI_R
1	1	1	2	2	2	1	ESI_R
1	1	1	2	2	2	2	ESI_R
1	1	2	1	1	1	1	MCAID
1	1	2	1	1	1	2	MCAID
1	1	2	1	1	2	2	MCAID
1	1	2	1	2	1	1	MCAID
1	1	2	1	2	1	2	MCAID
1	1	2	1	2	2	1	MCAID
1	1	2	1	2	2	2	MCAID
1	1	2	2	1	1	1	ESI_A
1	1	2	2	1	1	2	ESI_A
1	1	2	2	1	2	1	ESI_A
1	1	2	2	1	2	2	ESI_A
1	1	2	2	2	1	1	ESI_A
1	1	2	2	2	1	2	ESI_A
1	1	2	2	2	2	1	ESI_A

STATE OF HAWAI'I
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CURRENT STATUS OF INSURANCE COVERAGE IN THE STATE OF HAWAI'I

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
1	1	2	2	2	2	2	ESI_A
1	2	1	1	1	1	1	DUAL
1	2	1	1	1	1	2	DUAL
1	2	1	1	1	2	1	DUAL
1	2	1	1	1	2	2	DUAL
1	2	1	1	2	1	1	DUAL
1	2	1	1	2	1	2	DUAL
1	2	1	1	2	2	1	DUAL
1	2	1	1	2	2	2	DUAL
1	2	1	2	1	1	1	ESI_R
1	2	1	2	1	1	2	ESI_R
1	2	1	2	1	2	1	ESI_R
1	2	1	2	1	2	2	ESI_R
1	2	1	2	2	1	1	ESI_R
1	2	1	2	2	1	2	ESI_R
1	2	1	2	2	2	1	ESI_R
1	2	1	2	2	2	2	ESI_R
1	2	2	1	1	1	1	MCAID
1	2	2	1	1	1	2	MCAID
1	2	2	1	1	2	1	MCAID
1	2	2	1	1	2	2	MCAID
1	2	2	1	2	1	1	MCAID
1	2	2	1	2	1	2	MCAID
1	2	2	1	2	2	1	MCAID
1	2	2	1	2	2	2	MCAID
1	2	2	2	1	1	1	ESI_A
1	2	2	2	1	1	2	ESI_A
1	2	2	2	1	2	1	ESI_A
1	2	2	2	1	2	2	ESI_A
1	2	2	2	2	1	1	ESI_A
1	2	2	2	2	1	2	ESI_A
1	2	2	2	2	2	1	ESI_A
1	2	2	2	2	2	2	ESI_A
2	1	1	1	1	1	1	DUAL
2	1	1	1	1	1	2	DUAL
2	1	1	1	1	2	1	DUAL
2	1	1	1	1	2	2	DUAL
2	1	1	1	2	1	1	DUAL
2	1	1	1	2	1	2	DUAL

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
2	1	1	1	2	2	1	DUAL
2	1	1	1	2	2	2	DUAL
2	1	1	2	1	1	1	MIL_R
2	1	1	2	1	1	2	MIL_R
2	1	1	2	1	2	1	MCARE
2	1	1	2	1	2	2	MCARE
2	1	1	2	2	1	1	MCARE
2	1	1	2	2	1	2	MCARE
2	1	1	2	2	2	1	MCARE
2	1	1	2	2	2	2	MCARE
2	1	2	1	1	1	1	MCAID
2	1	2	1	1	1	2	MCAID
2	1	2	1	1	2	1	MCAID
2	1	2	1	1	2	2	MCAID
2	1	2	1	2	1	1	MCAID
2	1	2	1	2	1	2	MCAID
2	1	2	1	2	2	1	MCAID
2	1	2	1	2	2	2	MCAID
2	1	2	2	1	1	1	DP
2	1	2	2	1	1	2	DP
2	1	2	2	1	2	1	DP
2	1	2	2	1	2	2	DP
2	1	2	2	2	1	1	DP
2	1	2	2	2	1	2	DP
2	1	2	2	2	2	1	DP
2	1	2	2	2	2	2	DP
2	2	1	1	1	1	1	DUAL
2	2	1	1	1	1	2	DUAL
2	2	1	1	1	2	1	DUAL
2	2	1	1	1	2	2	DUAL
2	2	1	1	2	1	1	DUAL
2	2	1	1	2	1	2	DUAL
2	2	1	1	2	2	1	DUAL
2	2	1	1	2	2	2	DUAL
2	2	1	2	1	1	1	MIL_R
2	2	1	2	1	1	2	MIL_R
2	2	1	2	1	2	1	MCARE
2	2	1	2	1	2	2	MCARE
2	2	1	2	2	1	1	MCARE

STATE OF HAWAI'I
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CURRENT STATUS OF INSURANCE COVERAGE IN THE STATE OF HAWAI'I

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
2	2	1	2	2	1	2	MCARE
2	2	1	2	2	2	1	MCARE
2	2	1	2	2	2	2	MCARE
2	2	2	1	1	1	1	MCAID
2	2	2	1	1	1	2	MCAID
2	2	2	1	1	2	1	MCAID
2	2	2	1	1	2	2	MCAID
2	2	2	1	2	1	1	MCAID
2	2	2	1	2	1	2	MCAID
2	2	2	1	2	2	1	MCAID
2	2	2	1	2	2	2	MCAID
2	2	2	2	1	1	1	MIL_A
2	2	2	2	1	1	2	MIL_A
2	2	2	2	1	2	1	MIL_A
2	2	2	2	1	2	2	MIL_A
2	2	2	2	2	1	1	MIL_A
2	2	2	2	2	1	2	MIL_A
2	2	2	2	2	2	1	NATIVE
2	2	2	2	2	2	2	NOCOV

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HAWAI'I HEALTH
CONNECTOR

Memorandum

TO: Board of Directors
FROM: Tom Matsuda, Interim Executive Director TM
DATE: February 10, 2014
RE: Sustainability Planning

This memo documents the guidance provided by the Board of Directors to Connector staff regarding a proposed framework for developing a sustainability plan for the Hawai'i Health Connector.

Key Affordable Care Act (ACA) and state law factors impacting sustainability

1. Extension of deadline to spend Section 1311 federal grants
    a. Current ACA rule:
        i. IT design and development funds: Must be obligated by 12/31/14
        ii. Operations and Maintenance funds: Must be spent by 12/31/14
    b. As of 11/30/13, the Connector had about $110 million unobligated
    c. The Connector is asking its federal funding agency (CCIIO) for an extension of both deadlines to 12/31/15. It is unclear when the decision will be made.

2. Definition of small business, for access to SHOP[1] and small employer tax credits:
    a. Current state law: 50 employees or less
    b. State option: Increase to 100 employees before 2016
    c. 2016 ACA mandate: Increases definition to 100 employees nationwide

3. Options regarding large employers (over 100 employees):
    a. Current ACA rule:
        i. SHOP is only for small employers until 2017

[1] Small Business Health Options Program (SHOP) refers to the portion of the exchange system that allows small businesses to select health insurance plans for their employees, and allows their employees to enroll in a plan.

ii. Small business tax credit expires end of 2016

b. State option: Allow large employers to use SHOP starting in 2017

4. ACA Innovation Waiver (ACA Section 1332)[2]:
   a. Innovation waivers can take effect no sooner than January 1, 2017
   b. Federal administration has up to 180 days to make a decision on a state's waiver application

5. Other possible State options:
   a. Extend "grandmothered" health plans into 2016
   b. Set age band rating between 1:1 and 3:1 (currently at 3:1)
   c. Allow for direct enrollment

Proposal framework

This is an outline of a sustainability plan presented as a chronology between now and 2017. It provides 2 basic options, depending on whether the extension of time to spend federal grant funds in 2015 is approved or not during the current legislative session.

The Connector currently is focused on increasing enrollment in the Individual Marketplace to reduce the number of uninsured/underinsured Hawai'i residents and provide more affordable insurance options through the ACA individual tax credit ("Advance Premium Tax Credit" (APTC)) and Cost-sharing Reductions (CSR). That effort must continue in any sustainability plan as a core goal of the ACA. The key concept in this proposal is to supplement enrollment in the Individual Marketplace by examining the revenue opportunity provided by the Connector's Small Business Health Options Program (SHOP).

A sustainability plan built solely on individual enrollments is not sufficient because Hawaii's uninsured population is so low. There are about 100,000 uninsured in Hawaii (8% of the population), and about half of those people probably eligible for Medicaid. Enrolling as many of the uninsured as possible this year would certainly help support sustainability in 2015.

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[2] ACA Section 1332 allows states to apply for an innovation waiver to excuse individual states from certain requirements of the ACA. The rules for the waiver process have not yet been issued. The intent is to provide states with unique circumstances to take different paths to achieve the goals of the ACA.

Section 1332 includes the following:
"Before a state may submit a waiver, its legislature must pass legislation authorizing the state to apply for a waiver, and the state must receive public comments on its proposal. In addition, the state's proposal must include a list of the sections of the ACA the state desires to waive, its specific plans to offer coverage as comprehensive and affordable as under the ACA, and a detailed ten-year budget that is deficit neutral to the federal government. The applicable Secretary or Secretaries will have 180 days to make a determination on a state's submitted waiver application."

The following example illustrates the basic revenue equation:

- Connector fee applied to all plans sold: 2% of plan premiums
- Approximate operating cost of the Connector in 2015: $15 million
- Average premium of all plans on the Connector = X per month

Example 1: X = $500 per month

$500 per month x 2% = $10 per enrollment per month
$10 per month x 12 months = $120 per enrollment per year
$15 million annual operating cost ÷ $120 per enrollment = 125,000 enrollments needed

Example 2: X = $400 per month

$400 per month x 2% = $8 per enrollment per month
$8 per month x 12 months = $96 per enrollment per year
$15 million annual operating cost ÷ $96 per enrollment = 156,250 enrollments needed

The calculation of actual premiums applied to the 2% fee will be more complicated. Because of age band rating, the premium amount is different for each year of age. Thus an older average age demographic of enrollees will mean higher revenue per plan sold. Enrolling many "young invincibles" will mean lower revenue per plan sold. Also, for calculating revenue in 2014, the 2% fee for individual plans started January 1, 2014, while the 2% fee for SHOP plans will start on July 1, 2014.

SHOP has a large enrollment potential now[3] that could increase more in 2016 and 2017 due to planned ACA enhancements to SHOP. The ACA increases the definition of small business for SHOP from 50 to 100 employees in 2016 and allows large employers to enroll through SHOP starting in 2017. These expansions could increase the number of enrollments. On the other hand, potential choices by the State, such as 1:1 age rating, extension of "grandmothered" plans, or direct enrollment, could reduce the number of enrollments in SHOP. Therefore, the true revenue potential of SHOP isn't knowable yet. A sound sustainability plan should take these potential impacts on enrollment into account through alternative budget scenarios.

The ACA small business tax credit expires at the end of 2016. After that, there is no ACA mandate to

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[3] For example, the Oliver Wyman actuarial analysis of the Basic Health Plan Option for Hawaii (dated February 7, 2013), prepared for the Insurance Division, DCCA, estimated of the number of people enrolling through SHOP in 2014 as follows:

- Low estimate: 52,000
- High estimate: 104,000
- Total lives covered in the small group market: 207,000

Unfortunately, we have not found estimates of the number of potential small businesses using SHOP who would be eligible for the small business tax credit.

motivate employers to go through SHOP. This means that SHOP functionality and user experience by that time must provide so much value and convenience to employers that they want to enroll their employees through SHOP and are willing to bear the additional cost (either through the existing 2% fee or through a replacement revenue mechanism adopted by the Legislature) as an acceptable trade-off for that service.

If we build a plan that takes these unpredictable ACA changes to SHOP into account over the next 3 years and we also acknowledge the current reality of our situation by having a plan for system improvements and cost cutting, then we start to have a credible context for a sustainability plan. If we are successful in realizing the potential to increase online SHOP enrollments, the vast majority of those enrollments will be by employers who are subject to Prepaid. This means that Hawaii will have successfully leveraged the Connector's federal funding to substantially modernize and upgrade the State's Prepaid enrollment system.

Option 1 (Assumes extension of grant funds through 2015)

A grant extension gives us breathing room to improve the system, increase enrollment in both Individual and SHOP marketplaces, and work out a long term sustainability plan with State partners. The duration of the grant extension would be a critical factor. At this time, we have requested an extension but there is no indication from our federal partners when a decision will be made.

1. Present to October 2014

    a. Continue system improvement (performance/usability) to increase enrollment. Focus on Individual Marketplace enrollment to March 31. Then focus on improvements to SHOP to make it more attractive and useful to small businesses. Finish improvements before May 1 to accommodate the push to enrollment for small businesses with plan years starting July 1, 2014.
    b. Continue to enhance and improve education and outreach functions of the Hi'i Ola program, to build public understanding about the ACA and the Connector. Prepare to support and expand the Navigator program after federal funding expires.
    c. Establish metrics/enrollment goals to evaluate progress towards sustainability in 2015 and 2016. Tie metrics to 2015 and 2016 budget forecasts and potential changes to the small group market.
    d. Work with the Legislature and the State Administration to support the planning study by the Governor's Office, including greater coordination with the Healthcare Transformation initiative.
    e. Find ways to reduce ongoing operating and maintenance costs.

2. November 2014 to December 2015

    a. 2nd Open Enrollment period begins November 15, 2014. Aim to have a fully functioning and first-class user experience in the Individual Marketplace by then. Work to increase enrollments.
    b. Continue SHOP improvements to functionality and usability. Provide training to the small business community about the ACA and SHOP. Use marketing to attract businesses that have a January 1, 2015 plan year start. Support and expand the Navigator program.
    c. Finalize all system development including approved interfaces with State partners.
    d. Consider proposing legislation in the 2015 session to increase the SHOP definition of small business to 100 employees. Even if this doesn't happen, prepare later in the year to handle larger enrollment volume when the federal mandatory increase to 100 employees takes effect in 2016.
    e. Work with the Legislature and the State Administration planning process to propose a policy framework for evaluating an ACA innovation waiver as an optional action. Due to the complexities and procedural requirements for an innovation waiver, consider legislation to set the groundwork in the 2015 session.
    f. Regularly evaluate the marketplace system, enrollment and sustainability progress against previously established performance metrics. At regular intervals, assess the current and projected impact of ACA small business market changes on SHOP enrollment and revenue, and project the possible revenue impact of having large employers enroll through SHOP in 2017.

3. 2016 and beyond

    a. Decide whether an application for an Innovation Waiver is necessary for Hawaii.
    b. If necessary, work with the Legislature and the State Administration on legislation for an Innovation Waiver in the 2016 legislature. Legislative action is a prerequisite to filing a waiver application. The federal government has up to 180 days to make a waiver decision, so the application must be filed no later than July 1, 2016 if it is to take effect on January 1, 2017, the earliest possible date under the ACA.
    c. If a waiver is unnecessary or is denied, consider legislation to expand SHOP to include large group market enrollments starting in 2017.

Option 2 (Assumes extension of grant funds is denied)

Assuming the breathing room provided by the grant extension does not happen, Option 1 is accelerated:

1. The current board planning process focuses on completing the details of this plan, establishing realistic budgeted revenue and expense targets, and providing metrics/milestones/scenarios to gauge progress towards sustainability against those targets. This validates the plan for the Legislature and State Administration and provides an objective basis for legislative decisions.
2. The planning study proposed by the State administration also will have to happen concurrently during this session instead of afterwards, supported by our board planning work.
3. If the results of (1) and (2) above indicate that the Connector likely is not sustainable in 2015 without the federal funding extension, then that finding becomes an objective basis for a revenue decision by the Legislature in this 2014 session, but only for calendar year 2015. In other words, the temporary infusion of state funding would serve the same function that the federal grant extension would have had: gives us breathing room in 2015 to take the actions outlined in Option 1. Revenue for 2016 can be considered, if necessary, in the 2015 session.

Under both options, a major goal is to be able to make an informed final decision about applying for the Innovation Waiver before the 2016 legislative session begins. If the objective conclusion is that the Connector is sustainable long term, then the scope of the waiver application could be reduced or eliminated.

If, on the other hand, the conclusion is that the Connector is not sustainable long term even with SHOP enhancements, then major changes will have to be requested in the waiver application. The process outlined in Option 1 will have provided objective criteria and measurements to substantiate the application. Options could include, for example, a waiver of the SHOP requirement for Hawaii.

Obviously, this plan outline will have to be supplemented with more details, including enrollment/revenue and cost reduction scenarios, in the next step of our planning process. The challenge for our planning process, as explained above, is that there are many changes impacting our enrollment in the next three years, and many of those changes will be unpredictable external decisions beyond our control.

HAWAII HEALTH
CONNECTOR
Financial Overview
FY2014 through December 31, 2013

Operating Budget vs. Actual

Six Months Ended December 31, 2013

	Six Months Ended December 31, 2013					
	Operating Budget	Actual	Budget Over (Under) Actual	% variance	FY14 Total Budget	% Operating Budget Remaining
Support & Revenue						
Federal Grants	93,378,788	21,502,866	71,875,922	77%	138,853,510	85%
Subrecipient Grants	(22,238,718)	(1,761,273)	(20,477,445)	92%	(28,105,400)	94%
Issuer Fees	-	-	-	-	1,068,501	100%
Other Grant Revenue	-	38,000	(38,000)	-	-	-
Non-Grant Revenue	-	763	(763)	-	-	-
Total Support & Revenue	71,140,070	19,780,356	51,359,714	72%	111,816,611	82%
Expenditures						-
Personnel Costs	3,062,069	2,384,928	677,141	22%	6,124,138	61%
IT Contracts - Build	45,488,842	8,410,338	37,078,504	82%	64,752,714	87%
IT Contracts-Maintenance & Operations	1,671,138	1,051,597	619,541	37%	5,013,411	79%
Non-IT Contractual Services	13,763,250	5,019,379	8,743,871	64%	19,824,174	75%
Other Non-IT Contracts	5,734,173	413,622	5,320,551	93%	11,390,173	96%
Equipment	142,001	3,682	138,319	97%	1,142,000	100%
Travel	582,001	68,289	513,712	88%	1,188,000	94%
Supplies	208,000	152,146	55,854	27%	350,500	57%
Other	488,596	498,211	(9,615)	-2%	963,000	48%
Total Expenditures	71,140,070	18,002,192	53,137,878	75%	110,748,110	84%
Net Revenues over Expenditures	-	1,778,164	(1,778,164)		1,068,501	

Operating Budget vs. Actual

Quarter Ended December 31, 2013

	Three Months Ended December 31, 2013			
	Operating Budget	Actual	Budget Over (Under) Actual	% variance
Support & Revenue				
Federal Grants	35,576,700	11,615,068	23,961,633	67%
Subrecipient Grants	(12,441,741)	(1,599,687)	(10,842,054)	87%
Issuer Fees	-	-	-	-
Other Grant Revenue	-	38,000	(38,000)	-
Non-Grant Revenue	-	325	(325)	-
Total Support & Revenue	23,134,960	10,053,705	13,081,254	57%
Expenditures				
Personnel Costs	1,648,807	1,167,294	481,513	29%
IT Contracts - Build	10,618,143	4,588,826	6,029,317	57%
IT Contracts-Maintenance & Operations	1,671,138	527,693	1,143,445	68%
Non-IT Contractual Services	5,459,271	2,138,264	3,321,007	61%
Other Non-IT Contracts	3,114,000	173,507	2,940,493	94%
Equipment	-	1,176	(1,176)	0%
Travel	303,003	28,304	274,699	91%
Supplies	104,500	136,847	(32,347)	-31%
Other	216,098	218,751	(2,653)	-1%
Total Expenditures	23,134,960	8,980,661	14,154,298	61%
Net Revenues over Expenditures	-	1,073,044	(1,073,044)	

Variance Analysis- Revenue

Six Months Ended December 31, 2013

- YTD Grant revenue $50 million lower than budget
  - Delay in completion of Exchange
  - IT build, Contact Center, & Outreach
  - Operating budget of $71 million for Q1&2 FY2014.

Variance Analysis- Subrecipient grants

Six Months Ended December 31, 2013

Subrecipient grants:

- Q1 & Q2 budget of $22 million
- < $2.0 million expended.
  - Delays in expending $:
    - Marketplace Assister Grants- $2.7M
    - State cost allocation- $4.5 million
    - State Partners - $11.8 million

Variance Analysis- Expenditures

Three and Six Months Ended December 31, 2013

IT Contracts- Build:

- Six Months Ended 12/31/13:
  - Actual 81% lower than budget
  - Significant "budgeted" deliverables of $37M pending at 12/31/13.
- Quarter Ended 12/31/13:
  - Actual 57% lower than budget
  - $6 million of "budgeted" deliverables pending at 12/31/13

Variance Analysis- Expenditures (continued)

Six Months Ended December 31, 2013

Personnel Costs:

- Actual 22% lower than budget
- Actual FTEs of 43 versus 53 budgeted

IT Contracts- Maintenance & Operations:

- Actual 37% lower than budget
- Actual M&O date was delayed

Variance Analysis- Expenditures (continued)

Six Months Ended December 31, 2013

NON-IT Contracts:

Description	Budget	Actual	$ Budget Over (Under)	% Variance	Total FY2014 Budget
Contact Center	$ 4,887,000	$ 1,786,000	$ 3,101,000	63%	$ 6,023,000
Outreach/ Public Relations	8,171,000	2,156,000	6,015,000	74%	12,736,000
Legal	705,000	1,077,000	(372,000)	(53%)	1,065,000
total	$13,763,000	$ 5,019,000	$ 8,744,000		$19,824,000

Variance Analysis- Expenditures (continued)

Six Months Ended December 31, 2013

Non-IT Contract Expenditures:

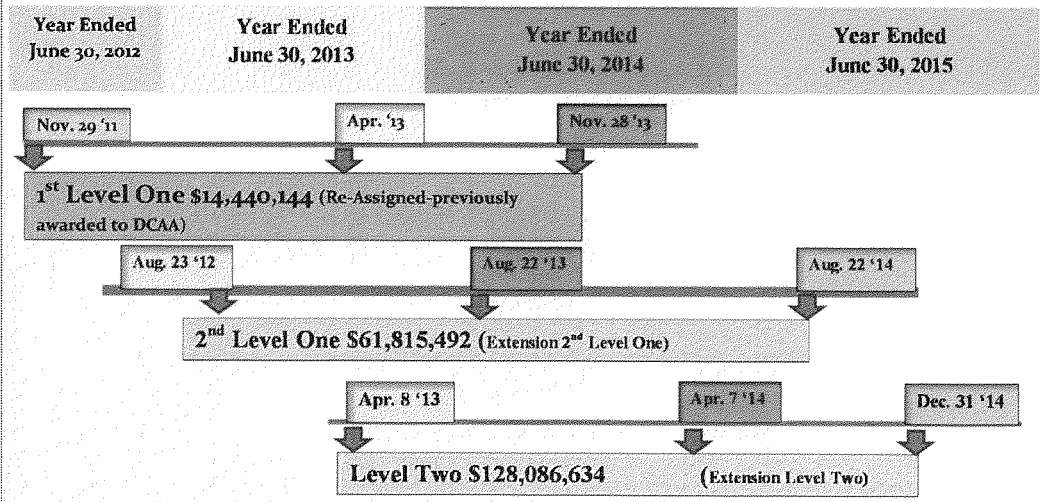
- **Contact Center**
  - Actual lower than budget due to delay in delivery of CRM deliverable.
  - Still pending delivery.
- **Outreach and Public Relations**
  - Media and PR increased at a pace slower than budgeted.
  - Media curbed slightly due to technology delays
- **Legal**
  - Actual is 53% or $372,000 greater than budget.
  - Additional expenses due to accelerated timing of contracts
  - Legal issues associated with problems with launch of Exchange.
  - Inside Counsel performed de facto CIO role during most of Q2.
  - Expectation that legal costs will exceed total FY 14 budget by $400,000.

Variance Analysis- Expenditures (continued)
Six Months Ended December 31, 2013

Other NON-IT Contracts:

Description	Budget	Actual	$ Budget Over (Under)	% Variance	Total FY2014 Budget
Mailing	$ 2,167,000	$ 0	$ 2,167,000	100%	$ 4,333,000
Evaluation/ Monitoring	1,233,000	31,000	1,202,000	98%	2,467,000
Consultants/ Temporary Services	1,074,000	383,000	1,321,000	78%	2,700,000
Bank/ Lockbox Charges	630,000	0	630,000	100%	1,890,000
Total	$ 5,734,000	$ 414,000	$5,320,000		$ 11,390,000

Grant Timeline



Grant Budget vs. Actual
2nd Level One
Grant Inception to December 31, 2013

	2nd Level One Grant Budget	Actual $ Incurred	Remaining 2nd Level One Grant $	% Remaining
Revenue	$ 61,815,492	$30,742,564	$ 31,072,928	50%
Expenditures				
Salaries & Wages	$ 3,650,000	$ 3,195,026	$ 454,974	12%
Fringe Benefits	1,460,000	359,447	1,100,553	75%
Equipment	142,000	93,629	48,371	34%
Supplies	24,600	27,070	(2,470)	-10%
Travel	209,300	147,195	62,105	30%
Other	704,604	741,400	(36,796)	-5%
IT Contracts	50,984,000	22,412,674	28,571,326	56%
Non-IT Contracts	4,640,988	3,812,495	828,493	18%
Total Expenditures	$ 61,815,492	$30,788,937	$ 31,026,555	50%

Grant Budget vs. Actual
Level Two
Grant Inception to December 31, 2013

	Level Two Grant Budget	Actual $ Incurred	Remaining Level Two Grant $	% Remaining
Revenue	$128,086,634	$ 11,887,475	$ 116,199,159	91%
Expenditures				
Salaries & Wages	$ 6,144,500	$ -	$ 6,144,500	100%
Fringe Benefits	2,590,300	304	2,589,996	100%
Equipment	3,946,350	373	3,945,977	100%
Supplies	650,500	119,986	530,514	82%
Travel	3,712,275	40,526	3,671,749	99%
Other	1,353,800	80,433	1,273,367	94%
In Person Assisters	21,000,000	477,021	20,522,979	98%
IT Contracts	41,626,802	5,038,659	36,588,143	88%
Non-IT Contracts	47,062,107	6,079,247	40,982,860	87%
Total Expenditures	$128,086,634	$ 11,836,550	$ 116,250,084	91%

Grant Funding Obligated

Contract Inception to December 31, 2013

Contractor Name	Contract Amount	Less: M&O Subsequent to 12/31/14	Expended to Date (12/31/13)	Remaining Obligated Balance
Allen Communication Learning Services	$ 292,961		$ 283,173	$ 9,788
CGI Technologies and Solutions, DDI	49,424,338		18,750,228	30,674,110
CGI Technologies and Solutions, O&M	14,441,126	(8,327,280)	1,044,263	5,069,583
CGI Technologies and Solutions, Inc. Total	63,865,464	(8,327,280)	19,794,491	35,743,693
Mansha Consulting, LLC Total	13,166,949		7,818,065	5,348,884
Maximus DDI Total	3,878,574		1,073,217	2,805,357
Maximus O&M Total	4,967,095	(1,687,290)	712,900	2,566,905
Maximus Total	8,845,669	(1,687,290)	1,786,117	5,372,262
Milici Valenti Ng Pack Inc. Total	1,992,815		1,830,305	162,510
Oahu Publications, Inc. Total	1,200,000		917,799	282,201
Public Consulting Group Inc. Total	4,150,330		3,377,059	773,271
Turning Point Global Solutions LLC Total	1,476,821		1,099,671	377,150
	$ 94,991,009	$ (10,014,570)	$ 36,906,680	$ 48,069,759

Note: An obligation to the State of Hawaii Department of Health and Human Services is included in the FY2014 operating budget and will be included as obligated once negotiations conclude with a signed agreement between the Connector and DHS.

Mr. LANKFORD. Thank you.
Mr. Sharfstein.

STATEMENT OF JOSHUA SHARFSTEIN, M.D.

Dr. SHARFSTEIN. Thank you, Chairman Lankford, Chairman Jordan, Ranking Member Speier, Ranking Member Cartwright, and other members of the committee. I appreciate the opportunity to testify today. It is true that I used to staff this committee, I used to be one of the people sitting along the back wall. I think I can say that every staffer wonders what it would be like to sit on this side of the microphone, and after the hearing I will be able to tell them.

As has been widely reported, Maryland has faced considerable IT challenges in establishing our State-based exchange. On October 1st the system barely worked at all. For weeks we struggled with a range of software and hardware problems. But we did not give up. We now expect to hit our enrollment goal. In fact, we expect to exceed it by 10 percent or more. We expect the number of enrollments in qualified health plans to come within 10 percent of what was predicted by independent experts and to exceed our expectations for Medicaid enrollments. By the time the dust settles, we could see enrollments more than 300,000 in Maryland.

Maryland's story includes decisions we wish we could make again, failures by multiple vendors, and too many IT frustrations to count. But Maryland's story is also about an exchange that is a lot more than a Website; it is about a State that is battling back and is looking towards the future. I have submitted detailed written testimony, so I will just make some key points.

First, the exchange is a lot more than the Website. It includes our close partnership with more than 2,000 brokers; it includes a very competitive market with four carriers offering 45 plans; we have some of the most competitive insurance rates in the Country, including dental plans; we have a Website that has a physician at work for each carrier and a community-based Navigator program that includes more than 30 grassroots organizations.

Second, we did face serious Website problems. We made a major misjudgment, in retrospect, initially in adopting a strategy of trying to buy commercial off-the-shelf software that could be configured for the purpose of the Affordable Health Care Act, instead of building something specifically for this purpose. The products that were advertised as being ready actually were defective and deficient. This caused immense frustration for consumers and at certain points made us wonder whether anyone would be able to enroll.

Third, rather than give up in the face of these IT challenges, Maryland tackled the problem head-on. Changes included new leadership, including when the governor asked the secretary for IT to step aside from her job and be the single leader for all IT development; hiring a general contractor, Optum/QSSI, the same company that helped fix the Federal Healthcare.gov; implementing hundreds of critical IT fixes; collaborating closely with carriers to allow for special types of enrollment for people who had trouble on the Website; manual workarounds which allowed us to process certain types of eligibility by hand; elbow grease by the gallon and the

incredible tough work of hundreds of consumer assistance workers; and, finally, a strong finish, with as much enrollment in the last two days as in the first 10 weeks or so.

As a result, as I said before, we expect not only to meet, but to exceed our enrollment goals. Quality and affordable health coverage is providing peace of mind and access to lifesaving care to families across Maryland, and is also going to reduce the hidden tax that all of us pay for poorly managed and uncompensated care under our unique system in Maryland of rate-setting for hospitals, which not only, I think, to Chairman Issa's point, is going to reduce the costs for uncompensated care within that system, but also we are using across all payers with no cost-shifting to address the fundamental challenge of cost in health care.

Let me finally say talk to next steps. In addition to the significant work and the hundreds of fixes that it took to get us to the point where we could exceed our enrollment goals, our secretary of information technology has led a process of figuring out the future for the Website, and after an extensive analysis the board, this week, voted to leverage the Connecticut IT solution in order to upgrade our Website. This is a model that has proven very effective and allows us to use something that works very well in time for the second open enrollment period.

As the chair of the board of the Maryland Health Benefit Exchange, I deeply regret the frustration that many Marylanders have experienced. I am also proud of the efforts of so many who have worked tirelessly to overcome the IT challenges and help their friends, neighbors, and fellow citizens gain access to affordable and quality health coverage.

Thank you for the opportunity to testify and I look forward to your questions.

[Prepared statement of Dr. Sharfstein follows:]

Testimony of

Joshua M. Sharfstein, M.D.
Secretary, Maryland Department of Health and Mental Hygiene
Chair, Maryland Health Benefit Exchange

Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs
Subcommittee on Energy Policy, Health Care, and Entitlements
Oversight and Government Reform Committee
U.S. House of Representatives

April 3, 2014

Chairman Jordan, Chairman Lankford, Ranking Member Speier, and Ranking Member Cartwright, and other members of the Oversight and Government Reform Committee, thank you for the opportunity to testify this morning on the Maryland Health Benefit Exchange.

On midnight of March 31, the first open enrollment period closed for the individual market in Maryland and across the country. Our goal had been to sign up -- from January 1, 2014 to this point in time -- 260,000 Marylanders in qualified health plans and Medicaid.

As has been widely reported, Maryland has faced considerable IT challenges in establishing our state-based exchange. On October 1, the system barely worked at all. For weeks, we struggled with a range of software and hardware problems.

But we did not give up.

New IT leadership helped to apply hundreds of fixes that substantially improved the website's performance. We expanded our call center so there were more resources available to citizens trying to enroll. Hundreds of consumer assistance workers across the state spent countless hours helping their friends and neighbors sort through the options.

We now expect not only to hit our enrollment goal but to exceed it by 10% or more. We expect our number of enrollments in qualified health plans to come within 10% of what was predicted by independent experts, and to exceed expectations for Medicaid enrollments. By the time the dust settles, we could see enrollments as high as 290,000 to 300,000.

Maryland's story includes decisions we wish we could make again, failures by multiple vendors, and too many IT frustrations to count.

But Maryland's story is also about an exchange that is a lot more than a website.

As we look to the future, Maryland intends to keep moving forward until the promise of affordable health care is made real for everyone across the state.

In this testimony, I will (1) provide an overview of state-based exchange implementation in Maryland; (2) describe the IT challenges that faced our website; (3) explain how we have tackled these challenges; and (4) close with comments about our next steps.

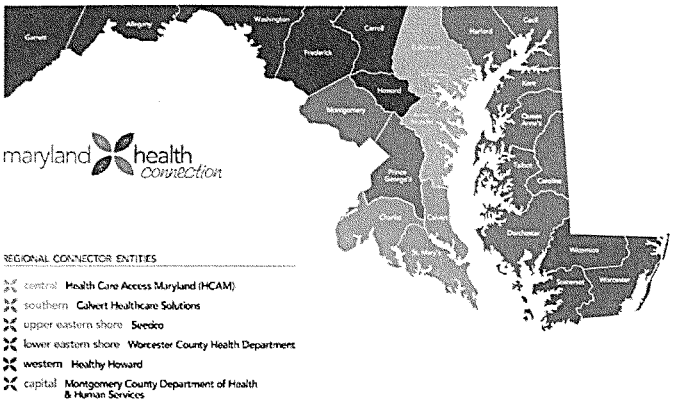
Overview of State-Based Exchange Implementation in Maryland

Maryland's implementation of a state-based exchange began with legislation passed in the 2011 session of the Maryland General Assembly. The initial legislation established the Maryland Health Benefit Exchange as a public corporation with a board of nine members, including three state employees and six selected from the public. In the first year, the exchange worked with the public, including more than 80 stakeholders, to conduct studies related to advertising and marketing, the navigator program, the insurance market, and other topics.

In the 2012 legislative session, a bill passed establishing a policy structure for the state-based exchange. Policies included keeping the individual and small group markets separate, allowing brokers to sell insurance in the exchange, setting market participation rules, and establishing a community-based navigator program.

As a result of these policies:

- More than 2,000 insurance brokers have taken training and are authorized to sell through Maryland Health Connection;
- We have a competitive market, with 4 carriers offering 45 plans. Of these, 11 are bronze, 16 are silver, 12 are gold, 3 are platinum, and 3 are catastrophic. In addition, 8 are PPO, 9 are POS, 20 are HMO, and 8 are EPO;
- We have among the most competitive insurance rates in the nation, with no exclusions for pre-existing conditions as required by law. According to a review by Kaiser Family Foundation, Maryland had the 5th-lowest rates in the country for a single 40-year old choosing a bronze plan, and the 12th-lowest rates for the second lowest-cost silver plan.
- We offer 20 dental plans. In addition, 36 of the medical plans offer embedded pediatric dental benefits;
- We have a website that provides information on physician network for each carrier and MCO offered through Maryland Health Connection; and
- We have a community-based navigator program that involves more than 30 grassroots organizations and public health agencies. (Figure 1).

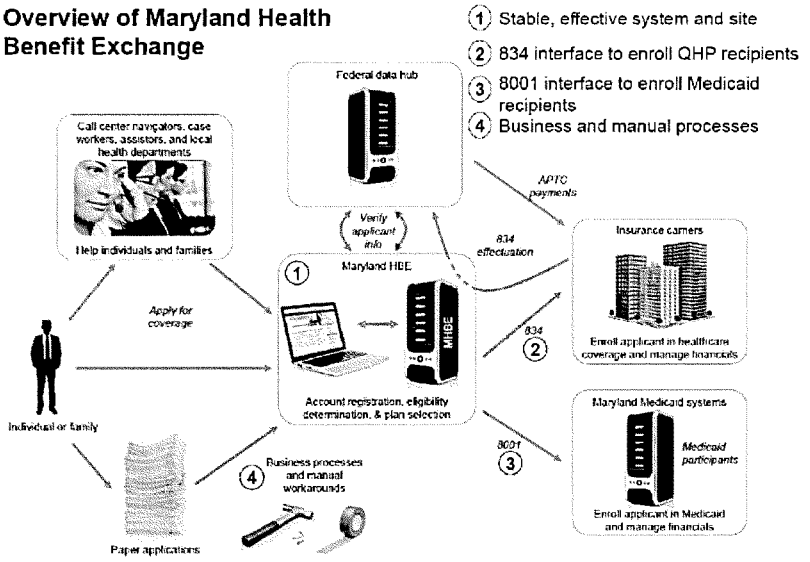


IT Challenges

The Affordable Care Act made a number of important reforms. It changed health insurance rules so that insurance companies will no longer be able to deny coverage to someone because of a preexisting condition, and so that insurance companies cannot drop someone if she gets sick.

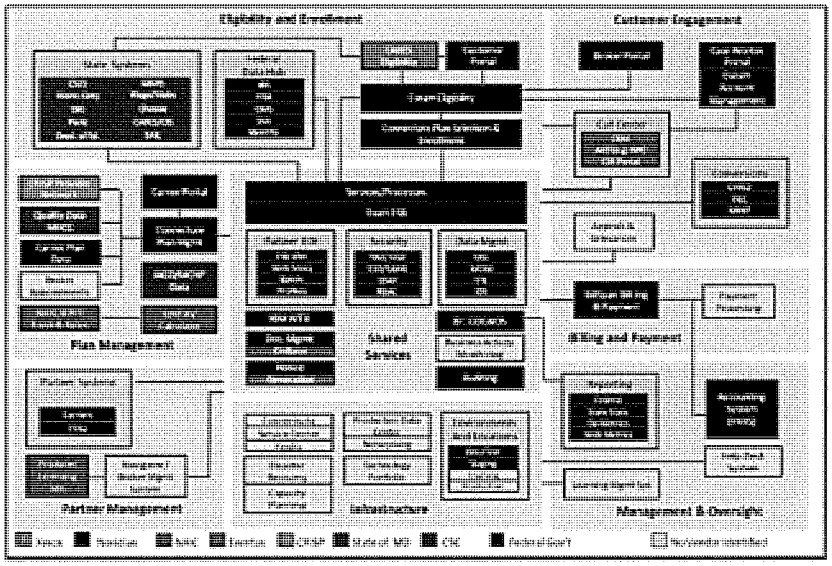
The law also seeks to increase the number of Americans with health coverage. It does this in two principal ways: (1) it expands Medicaid coverage for more citizens, and (2) it provides subsidies to low-income individuals and families to purchase private insurance.

In Maryland, we built the Maryland Health Connection website in order to make both of these steps possible. In addition to allowing Marylanders to shop for health insurance plans, the website is also used to determine whether Marylanders are eligible either to enroll in Medicaid, or to receive financial assistance to purchase private care.



The IT system is not able to make these eligibility determinations on its own. It must interact with a federal information database—called the "federal data hub"—for verifications, and with the Maryland Medicaid Information System for Medicaid enrollment. The website is interconnected with other IT systems as well. It interacts with insurance carriers for plan details, financial management, and coverage; and with consumer assistance organizations to provide access to the call center and others (Figure 2).

This adds up to a complex architecture. (Figure 3) Given this complexity, the IT build was far and away the most challenging aspect of exchange development.



Our path to an IT system began in 2011 with the development of system specifications and a Request for Proposals. We made a few key decisions, which, in retrospect, we wish we would have done differently. For example, we decided to give preference in the procurement to Commercial Off-the-Shelf or COTS products, with the reasoning that this would lower the risk as we would not have to build systems from scratch. We also aimed to fully upgrade our Medicaid eligibility and enrollment software at the same time.

The selection process for the IT vendor began in the fall of 2011 and took several months. The procurement review committee included six people: two from the Department of Health and Mental Hygiene, including our Chief Information Officer; two from the Department of Human Resources, including the CIO; one from the Department of Information Technology DoIT; and the CIO of the Maryland Health Benefit Exchange.

The selection process factored in a number of categories including understanding of the technical challenge, quality of staff and past performance (including reference checks), and meeting system requirements. Each proposal was reviewed independently by evaluation team members, and proposals were then qualitatively rated collectively in 6 full-day and 6 half-day sessions across all evaluation categories.

Based on this review, the team unanimously recommended the bid put together by Noridian Administrative Services, as the strongest technical proposal and a competitive price. A major technology partner to Noridian was IBM, which supplied both hardware and software, including the core COTS product called Curam for eligibility determination. As it turned out, the IBM/Curam product posed among the most serious and persistent problems, leading to challenges across our entire system.

The software development period had ups and downs. After initial concerns were identified, we changed project management approaches and were able to successfully complete an important demonstration of functionality with CMS in June 2013. However, progress over the summer was undermined by a bitter dispute between our prime contractor and one of its subcontractors.

In mid-September, the state leadership considered several options for the website's launch, including a limited launch with account creation only (for people to register with the system, and come back later to actually apply and choose a plan).

Governor O'Malley made the decision to go live on October 1 with several functions, including account creation, eligibility determination, and plan shopping. This decision, which I supported, was based on several factors:

- First, working around the clock, the IT team was able to demonstrate end-to-end function through the plan selection software.
- Second, even if there were glitches at launch, the expectation was that they would be short-lived: Our contractors had assured us that further improvements would be made to the system quickly.
- Third, launching would provide the opportunity to identify and address gaps in the system quickly.

In the days before October 1, the Maryland Health Benefit Exchange disclosed that IT glitches were expected and would be addressed as quickly as possible. The IT team also developed an approach of alerting everyone upon account creation of the potential for problems.

When October 1 arrived, however, the hardware crashed quickly and unexpectedly. Compounding the problem, product upgrades that our vendors assured us could be implemented in a couple of days took weeks to implement. Infighting between our prime contractor and its subcontractor intensified.

The COTS software, including Curam, proved to have multiple, serious defects that could not be quickly remediated. These defects included stuck cases, lost applications, and missing functionality. Some of these key problems remain unresolved.

It was clear that the project faced significant challenges and that change was needed.

Tackling the Challenges

Rather than give up in the face of these serious IT challenges, Maryland tackled them head on. Key steps include:

1. **New Leadership**. In early December 2013, Governor O'Malley asked the Secretary for Information Technology, Isabel FitzGerald, to step temporarily into a full-time role overseeing the IT development for Maryland Health Connection.

2. **A General Contractor.** In mid-December, the Maryland Health Benefit Exchange hired Optum/QSSI, a Columbia, Maryland-based company to serve as the General Contractor. This is the same company that has helped to stabilize healthcare.gov. Optum/QSSI immediately began to assist with project management, provide for manual work-arounds to system issues, and analyze the state's options moving forward. Optum/QSSI took over as prime contractor after the state ended its relationship with Noridian in February 2014.

3. **Critical IT Fixes.** Under Secretary FitzGerald's leadership, the IT team resolved hundreds of issues, including several that were most concerning to consumers. This materially improved the user experience and functionality of the system, and led to a surge of enrollments prior to December 31.

4. **Close Collaboration with Carriers.** In January, we worked with our carriers and the Maryland Insurance Administration to implement a "retroactive eligibility option" for Marylanders who had wanted coverage for January 1 but had run into problems on the website. Hundreds were able to take advantage of this opportunity. The state also created a last resort option for Marylanders through the state-funded high risk pool.

5. **Manual Workarounds.** We also developed a systematic approach to providing manual support for enrollments stuck in the IT system. Several thousand enrollments have been completed through this work-around process.

6. **Elbow Grease by the Gallon.** Our trained consumer assistance workforce has worked exceptionally hard to help Marylanders enroll through the IT system or through one of the available workarounds. In thank you letters, Marylanders have used these adjectives to describe navigators, call center workers, and others who have helped them: "outstanding," "diligent," "life-changing," "professional," "patient," "superb," "exceptional," "dedicated," "refreshing," "personable," "knowledgeable," "experienced," "calm," "pleasant," "informative," and "helpful."

7. **A Strong Finish.** As the end of open enrollment approached, we had several successful enrollment fairs and worked with our carriers to create a way for Marylanders who begin applications prior to March 31 to complete their applications and enroll in coverage for May 1, even if the enrollment process cannot be completed before midnight on March 31.

More Marylanders enrolled in qualified health plans during the last week in March than during the first 10 weeks after October 1.

As a result, we expect that by the time the dust settles, more than 290,000 Marylanders will have have enrolled in coverage since January 1, including more than 60,000 Marylanders in qualified health plans and more than 230,000 Marylanders in Medicaid. Incredibly, given the IT challenges Maryland has faced, this exceeds our initial goals by more than 10%.

Quality and affordable health coverage is providing peace of mind and access to life-saving care to families across Maryland. It is also going to reduce the hidden tax that all of us pay for poorly managed, uncompensated care.

In Maryland, there is a surcharge on every hospital bill in the state related to uncompensated care that institutions provide without a direct source of payment. Last week, the Health Services Cost Review Commission sent me an analysis of the cost of uncompensated hospital care in fiscal year 2013 for approximately 96,000 Marylanders who are now enrolled in Medicaid, but weren't last year.

That amount was $164.4 million.

In 2014, rather than utilize uncompensated care in hospitals, those 96,000 Marylanders will have insurance that provides access to a broad range of outpatient physicians and care coordination that can prevent illness and lower hospital costs -- and at the same time, promote health and productivity.

This data shows just how important the Medicaid expansion is, not only for those who are now covered, but for the long-term affordability of our healthcare system for businesses and families.

FY 2013 Hospital Charges Representing Uncompensated Care for 96,000 Marylanders

Hospital Inpatient	
Inpatient Stays	14,008
Unique Patients	11,784
Charges for Inpatient Stays	$127.2 million
Hospital Outpatient	
Outpatient Visits	42,839
Unique Patients	19,110
Charges for Outpatient Visits	$37.2 million

Source: CRISP analysis of HSCRC case mix data (7/1/2012-6/30/2013) and Maryland Medicaid MMIS enrollment files (2011-2013) provided by the Hilltop Institute. March 2014.

System Security

System security has been a high priority for Maryland. Prior to the the launch on October 1, we reviewed our security policies, safeguards, and procedures with both the Centers for Medicare & Medicaid Services and the Internal Revenue Service; engaged a third party security vendor to perform a security assessment, which included an onsite visit to the data center and penetration tests; conducted additional security assessments and remediated all high-risk findings. Since the launch, security teams at the state and the vendors have met weekly to review IT security status and make plans for continuous improvement.

Our general security operations include:

- On-site security engineers 24x7x365
- Multiple security tools
- Dedicated and fully managed firewalls
- Real-time alerts
- Advanced encryption of private health information.

The system has blocked hundreds of unauthorized or unverifiable access attempts per day with no known successful penetration of our systems or data.

Cost of IT Development

Maryland has paid approximately $55 million for system development (including software licenses and hardware) to Noridian, our original prime contractor. We expect about $8 million of this total may be able to reused with other systems. We will seek to recover as much as possible of the remainder from our original contractors and will share the recovery with the federal government.

Because definitions and the scope of projects vary considerably, it is difficult to compare IT expenditures between states, . In considering Maryland's IT investment, it is important to keep in mind that the state is using a legacy Medicaid eligibility system and has deferred modernization in order to implement a new system along with the Affordable Care Act. As a result, even after our system is remediated or upgraded, we expect the costs in Maryland to be in line with other states.

Next Steps

With the first open enrollment season drawing to a close, Maryland is developing a plan to address our remaining IT challenges and move forward to the second open enrollment period. Secretary of the Department of Information Technology Isabel FitzGerald is leading an evaluation of several options, including remediating of the current system, partnering with the federally facilitated marketplace, and leveraging another state's system to upgrade Maryland Health Connection.

As the chair of the board of the Maryland Health Benefit Exchange, I deeply regret the frustration that many Marylanders have experienced.

I am also proud of the efforts of so many who have worked tirelessly to overcome the IT challenges and help their friends, neighbors, and fellow citizens gain access to affordable and quality health coverage.

It is our job to fix Maryland Health Connection so that the website can serve as many Marylanders as possible as quickly and seamlessly as possible. We will not stop working on this challenge until we have succeeded.

Thank you for the opportunity to testify, and I look forward to your questions.

Mr. LANKFORD. Thank you.
Ms. Yang.

STATEMENT OF JEAN YANG

Ms. YANG. Thank you, Mr. Chairman. Chairman Jordan, Chairman Lankford, Ranking Member Cartwright, Ranking Member Speier, and members of the subcommittees, good morning. Thank you for the opportunity to testify about our experience implementing the Affordable Health Care Act in Massachusetts.

As you know, Massachusetts is very familiar with the framework of the ACA. In 2006, former Governor Mitt Romney worked with our State legislature to fashion an approach to expanding health coverage that drew ideas from both ends of the political spectrum. Once he took office in 2007, Governor Deval Patrick worked to bring the statutory framework to life, in close collaboration with our State's legislature, our health care providers, our business and labor leaders, our insurers, our consumer advocates, and countless others.

We are extraordinarily proud of the results we have achieved together over the past eight years. Virtually all of the Commonwealth residents are now ensured, at 97 percent. Ninety-one percent of our residents report having access to a primary care physician and 88 percent having seen their physician in the previous 12 months. On a whole host of measures, we are healthier.

At the same time, more employers are offering coverage and our State's budgets have been consistently balanced.

One of the most important lessons we have learned in the years since 2007 was that health care reform takes time. We refined our plan as we learned new lessons in collaboration with our partners, including the Bush and Obama Administrations. It has not always been easy, but we kept our eye on the goal of getting people adequately covered. As Governor Patrick has remarked, we learned early that health care is not a website.

We support the Affordable Health Care Act because it embodies the principles of our Massachusetts reforms and because it gives our State new tools to sustain and expand on our success. We know that it is already helping to put affordable coverage and care in the hands of Americans across the Country. In Massachusetts itself, since the ACA took full effect in January, over 200,000 more people have signed up for subsidized coverage. Almost 30,000 people have purchased unsubsidized ACA-compliant plans through our health connector. The health connector is also offering dental policies for the first time, with over 2,300 plans purchased to date by individual shoppers.

Even so, while implementing the ACA, we have experienced Website challenges. These are mainly due to failures of our system integrator. But with our new team in place we are on a path to go live with a functional, reliable exchange Website for the next open enrollment period.

Challenges with our system integrator and project management shortcomings impeded our progress in achieving our full vision for the Website by October 1st of last year. On that account, we decided to deploy only parts of the new system on that date. Given these constraints, and with many people encountering errors and

wait times even with the parts that were deployed, we have developed alternative pathways to support enrollment. These mechanisms have enabled us to protect and expand coverage with strong cooperation from our health insurers, providers, and consumer advocates. Many residents of the Commonwealth have experienced difficulties with some of these processes and we fully share their frustration. But we have not allowed Website problems to prevent us from meeting the ultimate goal of the ACA: getting people covered so that they can enjoy health and economic security.

Though the website challenges are mainly the result of an underperforming IT vendor, we are holding ourselves accountable for fixing them, and we are making progress. We have stabilized our system, eliminated a backlog of paper applications, and substantially reduced call center wait times. We continue to maintain strong data security protocols that meet Federal standards and have kept personal information of applicants safe from data breach, and we have a detailed plan to open up new parts of the Website only when we know they are ready for users. In the meantime, through the creativity and flexibility of our team, people are getting covered.

We have an unwavering commitment to ensuring quality, affordable health care for the people of Massachusetts, a commitment that kept us moving forward through both the peaks and the valleys of our State reforms, a commitment that keeps us moving forward today as we strive to realize the ACA's full potential for improving care and improving lives.

Thank you for your time. Look forward to your questions.

[Prepared statement of Ms. Yang follows:]

Testimony of Jean Yang, Executive Director of the Massachusetts Health Connector
to the Oversight and Government Reform Committee Subcommittee on Economic Growth, Job Creation and Regulation Affairs, and the Subcommittee on Energy Policy, Health Care and Entitlements
April 3, 2014

Chairman Jordan, Chairman Lankford, Ranking Member Cartwright, Ranking Member Speier and members of the Subcommittees.

Good morning. Thank you for the opportunity to testify this morning about our experience implementing the Affordable Care Act, including our work to enable our families and small businesses to secure coverage through the Commonwealth's Health Insurance Exchange.

As you know, Massachusetts is very familiar with the framework of the ACA. In 2006, former Governor Mitt Romney worked collaboratively with our state Legislature to fashion an approach to expanding health coverage that drew ideas from both ends of the political spectrum. It required the Commonwealth's adults to have coverage, while recognizing that lower- and some moderate-income families needed help to meet their obligation. It relied on private health insurance carriers to provide coverage, while bolstering competition and transparency through the creation of a state Health Insurance Exchange – the Massachusetts Health Connector. And it ended the practice of "free-riders," individuals who went without insurance or with extremely low levels of insurance, with the costs of their more significant care borne by the insured.

Once he took office in 2007, Governor Patrick worked to bring this statutory framework to life, in close collaboration with our state's Legislature, our health care providers, our business and labor leaders, our insurers, our consumer advocates and countless others.

We are extraordinarily proud of the results we have achieved together over the past eight years. Virtually all of the Commonwealth's residents are now insured, 97 percent. 91 percent of our residents report having access to a primary care physician, and 88 percent to having seen their physician in the previous 12 months. Health coverage has meant better access to needed

medications and greater financial security in the event one becomes sick. On a whole host of measures, we are healthier.

One of the most important lessons we learned in the years since 2007 was that health care reform takes time. We refined our plan as we moved forward and, in collaboration with our partners, including the Bush and Obama administrations, we refined the law to strengthen it as we learned new lessons. It has not always been easy, but we kept our eye on the goal of getting people adequately covered. As Governor Patrick has remarked, we learned early that health care is not a website.

Far from eroding private coverage or weakening the market, *more* employers offer coverage to their employees today than before our reform went into effect. And health reform has been affordable in Massachusetts: our state budgets have remained balanced, and our bond ratings have never been higher.

Alongside coverage expansion, we're aggressively tackling the broader problem of health care cost escalation. This challenge predates our health care reform efforts and is, as you know, a national one. Enhanced competition and greater oversight of premiums have already helped reduce base premium growth for small employers and individuals from 16% four years ago to under 3% today. Through innovative procurement strategies, we've held annual premium increases under 1% on average for our Commonwealth Care program. We've enacted and are implementing a comprehensive health care cost containment law designed to solidify and bolster this progress by encouraging smarter, more coordinated care with a heavy focus on prevention.

We support the Affordable Care Act because it embodies the principles of our Massachusetts reforms: shared responsibility for expanding coverage; a balance between private and public solutions; and the fundamental belief that health is a public good. We know that it is already helping to put affordable coverage and care in the hands of Americans across the country and that it has given to millions of our fellow citizens the security of knowing that they won't go bankrupt because they got sick. Because of our experience in Massachusetts, we are confident that it will continue to improve peoples' lives.

We also embrace the Affordable Care Act because it gives Massachusetts new tools to sustain and expand on our success. It opens the door to coverage for people facing real economic challenges who did not previously qualify for subsidized coverage in Massachusetts – for example, people who work hard but do not earn enough money to afford their employer's health insurance, and people who were just above our prior income ceiling for subsidized insurance but hardly economically secure.

The ACA also focuses additional resources on public outreach to explain the importance of having health insurance – and on establishing state Health Insurance Exchanges to gain coverage. It offers new tax credits to small employers for covering their employees, and gives young adults more time to stay on their parents' policies. It makes prescription drugs more affordable for seniors and preventive care more affordable for everyone. And it invests in innovation in the delivery of health care, nurturing the Massachusetts' health care system's own efforts to lower costs by providing *better, more coordinated* care.

In Massachusetts, over 200,000 more people have signed up for subsidized coverage. More than 26,000 people have purchased unsubsidized, ACA-compliant plans through our Health Connector. The Health Connector is also offering dental policies for the first time, and interest has been strong with over 2,300 plans purchased to date by individual shoppers.

Even so, while implementing the ACA, we have experienced website challenges. These are mainly due to failures of our system integrator. But with our new team in place, we are on a path to go-live with a functional, reliable Exchange website for the next open enrollment period.

Challenges with our system integrator and project management shortcomings impeded our progress in achieving our full vision for the website by October 1 of last year, so we decided to deploy only parts of the new system on that date. With these limits on our system – and with many people encountering errors and wait times even with the parts that were deployed – we have developed alternative pathways to support enrollment. These mechanisms have enabled us to protect and expand coverage, with strong cooperation from our health insurers, providers and consumer advocates. Many residents of the Commonwealth have experienced difficulties with some of these processes – and we fully share their

frustration. But we have not allowed website problems to prevent us from meeting the ultimate goal of the ACA: getting people covered so they can enjoy health and economic security.

Though the website challenges are mainly the result of an underperforming IT vendor, we are holding ourselves accountable for fixing them. And we are making progress. We have stabilized our system, eliminated the backlog of paper applications, and substantially reduced call center wait times. We continue to maintain strong data security protocols that meet federal standards and have kept personal information of applicants safe from data breach. And we have a detailed plan to open up new parts of the website only when we know they are ready for users. In the meantime, through the creativity and flexibility of our team, people are getting covered.

We will see this through, as we always have, because of our commitment to ensuring quality, affordable health care for the people of Massachusetts. This spirit – pervasive in the Commonwealth – kept us moving forward when it seemed impossible to break through a longstanding stalemate on how to expand coverage, and from there when we encountered occasional challenges and setbacks in implementing our state reforms. It keeps us moving forward today as we see the early promise of the Affordable Care Act in Massachusetts and strive to realize its full potential for improving care and improving lives.

Thank you for your time, and I look forward to your questions.

Mr. JORDAN. [Presiding] Thank you, Ms. Yang.
Mr. Lee.

STATEMENT OF PETER LEE

Mr. LEE. Good morning and thank you to Chairman Issa, Jordan, and Lankford, and Ranking Members Speier, Cartwright, and Cummings. I want to appreciate also the other distinguished members of the committee having us here. I am Peter Lee from Covered California and I am glad to share with you our early implementation lessons in California in launching the Affordable Health Care Act.

I think it is important that we are excited in California to, across a whole range of constituents, whether they be insurance agents, county workers, health care providers of a range of political positions who have come together in California to launch this to expand coverage. We are seeing the fruits of that effort today.

California is one of 15 State-based exchanges, and when we started we looked to the data and said that somewhere around 4 million Californians could benefit from Federal support, either expanded Medi-Cal or subsidies through Covered California. In a very few short years we have gone from being a 10 person organization to an organization with over 1,000 people. We are a very, very fast startup that is working to change history.

So how is it going so far? Well, you have heard some of the numbers: 1.2 million Californians now have coverage directly through Covered California. An additional 1.9 have coverage through Medi-Cal today, and over 800,000 are signed up for pending eligibility. This is close to 4 million Californians. Every single one of them went through CoveragedCA.com, our Website. Many of them were touched by humans in the enrollment process. And I really can't agree too strongly; again and again exchanges are about more than Websites. And I want to talk a little bit about what they are about.

But I also want to underscore when we think about State-based exchanges, there are five exchanges out there that, as of a month ago, had already covered more than 30 percent of those eligible. Those States included California, Rhode Island, Vermont, Washington, and Connecticut. Other States have done a very good job as well: Kentucky, New York. As of three days ago, California had brought coverage to more than 50 percent of those subsidy-eligible in the exchange. That is a remarkable number when you think about what it takes to grow a brand new and historic program.

So let me talk briefly about what it takes to make a State-based exchange work. And I would note that when we say work, we do not mean perfect. It has been rocky, it has been bumpy, and it will continue to be rocky and bumpy. This is historic. This is a very big change to the health care system. But, all in all, we feel good about the progress we are making. It takes, in our mind, three things for an exchange to work: it takes having affordable health plans delivering quality care; it takes effective marketing and outreach; and it takes effective enrollment.

In the area of affordable care, Covered California has been what is called an active purchaser. Thirty-three health plans originally expressed interest in participating in our marketplace. We selected 11. Covered California specifically went through a process of stand-

ardizing our benefit designs to give consumers better tools to make choices and understand what they were choosing between their plans. We ended up getting very competitive rates and we are optimistic those rates will stay very competitive and affordable. Right out of the gate, we have been giving consumers information to choose. That is having affordable plans that consumers can use their information to make the right choice for them.

Second element of success is effective marketing and outreach. Covered California has been reaching out to Californians across demographic mix, across languages through a whole range of marketing channels; through TV, through radio, through newspapers, but as, or more importantly, through over 250 groups anchored in local communities doing outreach and educating people about the importance and opportunities of enrolling in Covered California.

Finally, effective enrollment. It is more than about an IT system and it is a complex IT system. The enrollment system that we have, like the other people testifying with me here, has to connect with more than 11 different major databases, including the Federal Government, but also State systems. We have our system up and running. It has been up 91 percent of the time in the scheduled running time. It has served more than 12 million unique visitors.

It is working well but, more importantly than it working well, the over 25,000 Californians, these are county workers, these are licensed insurance agents, these are certified enrollment counselors in every community in the State have been helping literally millions of Californians get enrolled. That is why we think it is largely working in California, because Californians have stepped up. They have stepped up to talk to their neighbors, members of their churches, members of their schools to get them covered.

We do have lessons learned we can share. Those are in my written testimony.

And I look forward to responding to questions from the committee. Thank you very much.

[Prepared statement of Mr. Lee follows:]

COVERED CALIFORNIA

United States House of Representatives
Before the Committee on Oversight and Government Reform's
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs and;
Subcommittee on Energy Policy, Health Care and Entitlements

Written Testimony Submitted by:
Peter V. Lee
Executive Director
Covered California

April 3, 2014

Good morning, Chairman Jordan, Chairman Lankford, Ranking Member Speier, Ranking Member Cartwright and distinguished members of the committees. My name is Peter V. Lee, and I serve as the executive director of Covered California. It is an honor for me to be here in Washington, D.C., before this committee, to speak with you about the implementation of the federal Patient Protection and Affordable Care Act in California.

I sit before you today proud of what we have accomplished as a state and as a nation. Covered California, the state-based health care insurance exchange, stands with an array of partners in the privileged position of touching the lives of millions and making history. Thanks to the Affordable Care Act, the approximately 5 million Californians who were previously without health insurance now have new opportunities, new hope and new peace of mind. The Kaiser Family Foundation recently found that uninsured medical bills forced nearly 1 million Californians to use up all, or most, of their life savings in the past year. Nearly 1 million Californians spent less money on food for themselves and their families because of those bills, and hundreds of thousands of Californians made the painful choice of missing or skipping payments for their electricity, gas, rent or mortgage. Ultimately, more than 100,000 declared bankruptcy, all because they were uninsured and needed medical help. And many Californians who actually had health insurance have been surprised by gaps in their coverage.

That can now all come to an end, because together we have opened the doors to health care in America. People now have the promise of guaranteed issue, access to insurance they can afford and insurance that is fair for all. For the first time in our history, health care is now a right and not a privilege. We have done this by putting in place a competitive marketplace and giving consumers the tools to make better choices. And central to these changes has been not only the expansion of coverage, but also the reform of the individual and small-group insurance markets

to now reward the delivery of quality, affordable care, rather than rewarding health insurers that did a better job at risk selection and excluding from coverage those who most needed care.

Before I address where Covered California stands now, let me take a moment to reflect on what it took to get to this point. We are now four days after the end of the first open-enrollment period. Reaching this moment has not been easy. Today I want to share with you the lessons we've learned, including what we've done well in California and where we've stumbled in this historic launch.

OVERVIEW OF THE AFFORDABLE CARE ACT'S EXPANSION OF COVERAGE IN CALIFORNIA

Following the passage of the federal Patient Protection and Affordable Care Act in 2010, California's then Governor Arnold Schwarzenegger and our Legislature created the California Health Benefit Exchange, the first state exchange under the new law. Since then, under the leadership of Governor Jerry Brown and a new Legislature, California adopted the Affordable Care Act's provisions to expand the state's Medi-Cal program.

As you know, California is one of 15 state-based exchanges and was approved to develop and operate the marketplace in California to administer the coverage expansion elements of the Affordable Care Act. To operate as a state-based exchange, we needed to demonstrate to the Center for Medicare and Medicaid Services' Center for Consumer Information and Insurance Oversight (CCIIO) that we had the plans, systems in place and capacity to meet the federal requirements. To establish as a state-based exchange, we have requested establishment funds, provided regular reports on our status, participated in design reviews and audits of our systems and processes, and developed a blueprint that has detailed our plans for operating during the initial phase and our plan for sustainability. The oversight and review of our efforts by CCIIO has been rigorous and thorough.

Our early estimates were that as many as 4 million Californians would benefit from either federal subsidies or new expansion of Medi-Cal that California has implemented (Covered California serves as a single point of review for eligibility for both Medi-Cal, California's Medicaid program, and the advanced premium tax credits that can be used to support the purchase of a private plan through our marketplace).

Over the past two years, Covered California has received a series of federal grants to fund the initial establishment of the marketplace in California, totaling just over $1 billion. The funding we have received has been, and is being, used to develop, launch and enroll individuals in this new marketplace. The four main areas of expenditures are:

- Development of the online enrollment system (California Healthcare Eligibility Enrollment Retention System or "CalHEERS")
- Outreach, Education and Communications
- Service Center
- Eligibility and Enrollment
- Small Business Health Options Program (or SHOP)

(The budget details are included in Attachment 1, which is the fiscal report that was presented to our board in March.)

Covered California is an independent part of the State of California, overseen by a five member board. In August of 2011, I had the honor of joining Covered California as its first executive director. The board has provided ongoing leadership and direction on major policy issues and early on established a mission statement and set values that have guided us over the past years.

The mission of Covered California is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

The six values that the board has indicated should guide the work of Covered California are to be:

- Consumer-focused;
- Consistently focused on the affordability of care for families and small businesses;
- A catalyst for broader improvement in care and affordability;
- Operated always with the highest integrity;
- Anchored in working in partnership with others to achieve our mission; and
- Results driven – improving based on the evidence.

Covered California is a public-sector start-up that has grown rapidly in a few short years. When I joined the organization, we had 10 employees. Since then, we have strived to implement a program that would be nimble, innovative, self-sustaining and reflective of the people and spirit of California.

We now have more than 1,100 public employees. We have also engaged the services of contractors that are national and international leaders in areas of information technology,

consumer research, organizational development, marketing and sales. In addition, we have worked in close partnership with other state departments, including the California Department of Health Care Services, which oversees Medi-Cal, and the two entities that regulate the insurance industry in California, the California Department of Managed Health Care and the California Department of Insurance. We have also built partnerships with insurers, counties, consumer groups, community organizations, churches, schools, clinics, small businesses and tens of thousands of individuals who have been "on the ground" doing education, outreach, enrollment and organizing to make this historic effort work.

Today, because of these thousands of partners, we are delivering on the promise of health care for Californians, a promise that's been decades in the making and put forth by leaders from both sides of the aisle.

The title of this hearing is "Examining ObamaCare's Problem-Filled State Exchanges." There's no question that there have been problems, but that's to be expected in an undertaking this large and this historic. This is our nation's most significant health reform since the enactment of Medicare and Medicaid in 1965. We are literally recreating America's health insurance markets and dramatically expanding health coverage, and doing it in a timeframe that most people did not think was possible.

Some experts were doubtful that an enrollment system could be created in less than three years. We did it in 18 months, and, for the most part, it has worked.

I will be the first to admit our launch has not been perfect. Many have compared it to building the car while driving 70 miles an hour. Still, sitting before you today, I can say that California has much to be proud of, and we continue to work on many challenges, but we are learning and improving as we go.

OVERVIEW OF INITIAL ENROLLMENT

Before providing an overview of the major elements of our operation, I wanted to provide an update on our enrollment. When we began implementation of the Affordable Care Act in California, concerns were raised that low enrollment and an adverse risk mix would imperil the sustainability of the marketplace and increase rates.

Our preliminary numbers show that more than 1.2 million Californians enrolled in a Covered California health insurance plan by the end of March 31. With our decision to allow those who started the enrollment process by the deadline to complete their application by April 15th, the final number will certainly be higher.

In addition, more than 2 million more enrolled in California's expanded Medicaid plans, which we call Medi-Cal.

(See Attachment 2 for Covered California enrollment and Medi-Cal numbers. Note: this attachment will be provided on April 3rd, as Covered California is seeking to provide figures that reflect the final rush to enroll on March 31st.)

Covered California has used projections developed by the University of California as a reference point for our enrollment efforts. These "CalSIM" projections provided the basis for estimates of enrollment, not only for the initial open-enrollment period, but also for enrollment over future years. The CalSIM projections reflected estimated potential enrollment based on a "most likely" scenario (the "base enrollment") and high estimate ("enhanced enrollment"). Based on these projections, we estimated that by the end of the first open-enrollment period about 580,000 Californians would enroll under the "base enrollment scenario," and about 830,000 would enroll under the "enhanced enrollment scenario".

We recognize that not everyone who picked a plan will follow through and pay their premium. The health plans report that over 85 percent of consumers paid their premium for coverage starting in January. If that trend continues, Covered California will have over 1 million customers who will have effectuated their coverage and we will surpass the "enhanced enrollment scenario."

Recently both the University of California and Kaiser Family Foundation have done independent studies estimating there are about 2 million Californians eligible for subsidies. The Kaiser Family Foundation issued a report that summarized the enrollment status of subsidy-eligible individuals compared to their enrollment as of March 1st. At that point, with a month of open enrollment still to go, California was one of five states, along with Connecticut, Rhode Island, Vermont and Washington, to have topped the 30 percent mark in enrolling their subsidy-eligible population.

Each month Covered California has reported its enrollment statistics by race, age, language and metal tier selected. The most recent report, which covered October through the end of February, was released in March and is attached. Based on the data here are the key findings to date:

- Enrollees who self-identified as being Hispanic, Latino or Spanish-origin increased from 18 percent in the first three months to 32 percent of those enrolling in the first weeks of March
- We had nearly met our "base projection" for African-American enrollment
- We had more than doubled our "base projection" for Asian enrollment

- We had maintained steady growth among young adults ages 18-34
- Far more subsidy-eligible enrollees are picking Silver and Bronze plans. (This suggests our consumers understand the benefit of the cost-sharing subsidy and are getting the most coverage for their money.)

(See Attachment 3 for Race/Age/Language/Metal Tier Enrollments)

Again, we have just begun. During this initial open-enrollment period, Covered California has demonstrated a willingness and ability to learn and adjust. We continuously examined what we had accomplished, adjusted our strategies as necessary and directed more resources and effort where they were needed, whether that has been to adjusting our marketing or our policies for assisting consumers who struggled with enrolling to meet the December and March deadlines.

To provide broader context to Covered California's effort, I want to focus on the three elements that we consider to be necessary in order to have a successful state-based exchange:

- Providing affordable health plans;
- Effective marketing and outreach; and
- Effective enrollment.

HEALTH PLANS PROVIDING AFFORDABLE AND QUALITY CARE

The starting point of making a successful state-based exchange is having affordable health care plans. The ending point is making sure the people who enrolled get the quality care they need, deserve and have paid for.

While the federal subsidies provide crucial support to make care affordable for millions of Californians, underpinning that affordability is the premium charged by the health plans we contract with. The Covered California Board adopted the policy that we would be an "active purchaser." As such, we conducted a robust bidding and negotiation process, and Covered California has actively sought to create a more competitive marketplace that best serves consumers. Originally, 33 different health care providers reached out to us and expressed an interest in potentially joining Covered California. We ultimately selected 11 health plans to serve the individual market.

In every corner of California, consumers can choose from at least two health insurance companies. In the more populous regions of the state consumers can choose from among five or six. While the four largest plans in the individual market all participate in Covered California, we also have as active participants regional plans that are market leaders in specific areas and a number of plans that have historically only served the Medi-Cal population.

The rates submitted to Covered California for the 2014 individual market ranged from 2 percent above to 29 percent below the 2013 average premium for small-employer plans in California's most populous regions. Like the small employer market, the new individual market is "guarantee issue," but this is particularly impressive since the 2014 products include doctor visits, prescriptions, hospital stays and more essential benefits, protecting consumers from the "gimmicks and gotchas" of many insurance policies.

Another benefit of Covered California being an active purchaser is the development of standardized benefit designs. These standardized designs we put in place are crucial for consumers, and authorized by California law. Even health insurance plans that are not in Covered California's marketplace must offer a product that matches the standardized design in the individual market.

By standardizing the process, California has made it far easier for consumers to compare plans both inside Covered California and in the broader individual and small group markets. The standards are designed to facilitate access to health care and to make it clearer when a consumer's deductible does not apply. For instance, consumers can get four annual visits under a Bronze plan, without spending one dollar of their deductible. While our standard Silver plan has a deductible, many entire categories of service are never subject to the deductible. Some of our enhanced, subsidized Silver plans have little or no deductible and very low co-pays, such as a $3 office visit.

We designed plans that would provide access to care, without letting finances be a burden. By standardizing benefits, consumers can pick a plan based on value rather than obscure and incomprehensible variations in benefit design.

Besides allowing consumers to more easily compare plans, the standardization of benefits rightly focuses consumer attention on network differences. It is critical for consumers to know that networks are different, and one of the most important choices consumers have is which mix of "competing" delivery systems and clinicians they want to have as part of the plan they select.

Every health plan we selected is required to meet regulatory "network adequacy" standards to ensure that there are enough clinicians and hospitals — with clear geographic access standards — across the state. In California this means that every consumer must have access to a doctor within a minimum standard for network adequacy, which requires the plans to maintain a network of primary care physicians which are located within 30 minutes or 10 miles of a customer's home (for the California Department of Managed Health Care).

Covered California is continuing to monitor the individual companies and is working with California's Department of Insurance (California Department of Insurance) and the California

Department of Managed Health Care (DMHC) to make sure these standards are maintained and that all enrollees get covered in a meaningful and effective way.

Covered California has been working with both the health plans it contracts with and with their regulators to provide for continuity of care for individuals who are in treatment with particular providers that do not contract with their new plan. Ensuring continuity, however, does not mean that every consumer will always have "their" doctor as part of their plan. We know that some people no longer have the doctors they once did. That's part of what happens when a new system is put in place, when people change jobs and when larger employers change plans.

It is important to note that while some plans narrowed their networks, many did not, and across all plans offered, enrollees have a very broad choice of physicians and hospitals, but which plan they choose does make a difference.

Covered California produced a cross-plan combined directory, which was based on the provider network rosters submitted to us by each plan and used by those plans to represent the providers available to their enrollees. In addition to the well-known and long-standing challenges associated with health plans maintaining accurate lists of participating providers, the additional task of creating the ability for enrollees to check for providers across multiple plans was significant, especially given different provider licensing and naming conventions. While our first efforts for open enrollment were generally well received by consumers, concerns over the accuracy of the provider lists required us to suspend this functionality in February. Our goal remains to provide a true cross-plan directory that is accurate, reliable and consumer-focused.

Covered California is also pushing hard to bring plan-quality information to consumers — a full two years before the federal Quality Rating System will be available for enrollees. Already in California, enrollees can use standardized information on plan quality to assist in their selection, and we are aggressively pushing toward having this type of information based on the exchange enrollee experience as soon as open enrollment 2015.

Several other initiatives and contractual requirements of the qualified health plans highlight the focus on quality, the focus on addressing disparities in care, and network composition that are all reflections of Covered California's role as an active purchaser.

As is reflected in the mission statement adopted by the Covered California board of directors we are focused not just on coverage, but also on Californians getting access to quality, affordable care. In the coming months and years, this will be an increasing focus of our efforts.

EFFECTIVE MARKETING AND OUTREACH

For any exchange, having affordable plans is the foundation that then needs to be communicated to potential enrollees. How well Covered California and other exchanges succeed will depend greatly on how effectively they educate and engage consumers through marketing. Covered California developed an outreach, marketing and education plan with input from advisory groups, experts and others that has been used as a roadmap — with adjustments made based on lessons learned as we have progressed.

From the outset, Covered California has seen community mobilization and grass-roots education as the starting point for educating Californians about the benefits of coverage through the Affordable Care Act. Covered California made outreach and education grants that went to more than 250 trusted community-based organizations across the state, with funding totaling $39 million.

Organizations that received this grants included the Asian American Advancing Justice Los Angeles; Bienestar; California Black Health Network; Cal State LA University Auxiliary Services, Inc.; Community Health Councils; 2-1-1 San Diego; JWCH Institute Inc.; Los Angeles County Federation of Labor, AFL-CIO; Sacramento Employment and Training Agency; Service Employees International Union, Local 521 and ULTCW; The Los Angeles Gay and Lesbian Community Services Center; the Regents of the University of California; and Vision y Compromiso.

Our grantees supported education and outreach in 13 different languages, in all 58 counties. Covered California contracted with organizations that demonstrated they were trusted in their communities and could reach targeted regions and demographic sectors. Approximately 45 percent of the outreach and education funding was allocated to organizations that were part of, and could reach out to, our Latino population. Funding was also allocated to groups that specifically targeted the African-American community, the Asian-American community and based on where subsidy eligible Californians live.

We estimated that our grantees would reach nearly 9 million Californians. Covered California supported training of thousands of certified educators, but also supported hundreds of additional organizations that did not receive funding but wanted to participate in outreach and education activities – Covered California's "Community Outreach Network."

We coupled our community outreach with a broad marketing strategy. Covered California developed a multi-faceted marketing and advertising program that was geared to garner brand awareness and educate consumers about the costs and benefits of coverage. As we moved through the open enrollment period we included a "call to action" and promoted the actual enrollment in coverage. Covered California's marketing effort included a portfolio of multiple advertising channels (e.g., television, radio, social media, print collateral, billboard and out-of-

home, direct mail) and coordination with other groups such as the contracted health plans and foundations in California.

From the very beginning Covered California recognized the unique needs of Latino consumers. We worked closely with Latino firms and developed material and tactics specifically geared toward Latino communities. In particular, Covered California developed a radio, television and social media campaign that was weighted to those stations with high Latino listeners/viewers – both for Spanish-only and those who are English speaking. We did the same for our African-American and Asian consumers.

One part of Covered California's marketing strategy was to use social media to promote awareness, particularly among young people, African-Americans and Latinos. This effort included the ***Tell a Friend – Get Covered*** campaign which promoted the development of YouTube and other social content that could be shared through multiple platforms during the final months of open enrollment. When Covered California launched this campaign in December, many young people – and consumers in general – were focused on website problems rather than the opportunities for coverage. ***Tell a Friend – Get Covered*** was created to help change the debate, and encourage young people to engage in a social discussion about the Affordable Care Act and its benefits. The ***Tell a Friend – Get Covered*** project used influential voices and bloggers, and featured stars like Adam Levine, Pitbull, Tatyana Ali, Marlon Wayans and many more, including Richard Simmons. Five promotional videos began a viral discussion that included more than 2.7 million views. The launch and the promotion of a live-stream YouTube event generated more social content. The initiative got substantial news coverage with more than 50 broadcast segments and over 600 placements in magazines and newspapers. Overall the *Tell a Friend-Get Covered* campaign received 200 million impressions on Twitter, including a tweet from People magazine's "sexiest man alive" who thought coverage was the right discussion, and not websites.

Covered California built its marketing plan to be agile, so we could adjust things, reallocate resources and sharpen our focus as needed. In January, after doing early evaluation of the results of the first three months of open enrollment, we realized we still had not reached our base projections in Fresno or San Bernardino counties; and the enrollment of Latinos was substantially below the CalSIM base projections. At that point, we increased our Latino marketing by 73 percent in the first quarter of 2014 and provided additional focus and resources to seven specific regions in the state where we had relatively low enrollment, particularly in Latino and African-American communities. We zeroed in on those seven regions, where more of those populations lived, doing targeted community organizing and additional targeted advertising in ethnic media.

Dolores Huerta, one of the most trusted voices in the Latino community, joined our outreach efforts. She became a key spokeswoman throughout the state and issued a call to action that was grounded in Cesar Chavez's commitment to social justice. Covered California developed a new "Days of Action" social media campaign as part of this effort, and highlighted that the final day of open enrollment was Chavez's birthday and a state holiday.

Based on focus groups that Covered California conducted, we also adjusted our messaging in January, switching from an awareness campaign to one that spoke specifically to the benefits of affordability. In addition, we shifted the message to promote the in-person assistance available through thousands of agents, certified enrollment counselors and county workers – all free and all confidential. As more Californians enrolled, we began to feature real individuals who had signed up for one our health plans, to motivate and inspire others to do the same.

In February, Covered California rolled out our "I'm In" campaign ads — and the Spanish version, "Tengo un Plan" — showing the transformative effect Covered California is having on people's lives. In their own words, real enrollees told us how they feel to be covered and how they are benefiting from the federal Patient Protection and Affordable Care Act.

The shift in strategies and messaging appears to have had an impact. In our first three months of open-enrollment, the number of enrollees who self-identified themselves as Hispanic, Latino or Spanish-origin was 18 percent (compared to the proportion of subsidy eligible at somewhat above 40 percent). And, while some of this relatively low enrollment can be explained by the fact that it is likely many of those who enrolled before January were previously insured – and hence less likely to be Latino – this data heightened our focus. During January through March, enrollment rates among Latinos improved every month – with approximately 32 percent of those who enrolled in the first two weeks of March being Latino, and over 38 percent of those enrolling in Medi-Cal being Latino.

We also increased our African-American marketing by 23 percent in the first quarter of 2014. In the case of African-Americans, while they represent about 4 percent of subsidy eligible Californians, as of the end of February they represented only about 2.6 percent of enrollment. Covered California will almost certainly enroll more African-Americans than the "base enrollment" projection and our aspiration is to greatly exceed that projection — as we have for the enrollment in the Asian-American community.

In the coming weeks and months, Covered California looks forward to doing more evaluation and build for the second open enrollment period. Covered California needs to learn what worked and what did not, particularly with regard to Latino and African-American enrollment.

Even though we tested our print, radio and television ads and got feedback from stakeholders, focus groups and others – a full evaluation will help us revise our strategies and tactics for future enrollment.

EFFECTIVE ENROLLMENT

The third element that is central to the success of an exchange is having a smooth enrollment process. This includes the technology of the on-line enrollment website and the human assistance provided to individuals seeking to enroll.

California's online enrollment system, or CalHEERS, is an extremely large, and complex database, and set of consumer-facing tools. The system was built in compliance with federal and state requirements, including privacy and security safeguards. As I mentioned earlier, CalHEERS was built in half the time that most IT experts told us it would take, and it still went online on time and on budget.

While our online enrollment hasn't been perfect, it has worked for an overwhelming majority of customers, for an overwhelming majority of the time. We have had more than 12 million unique visitors to our website and the enrollment portal was up 92 percent of the time. This included nearly five days in February when the system was offline, which was the only significant unplanned outage in our entire six month period. When the system was operating, 90 percent of consumers received response times of two seconds or less.

The system interfaces with 11 other agencies, including the federal data service hub; California's Department of Health Care Services, which oversees Medi-Cal; California's Employment Development Department; the California Franchise Tax Board; and our CRM system that connects it to our service centers in Rancho Cordova, Fresno and Concord.

California's system has not been perfect, but it has functioned relatively well, especially in the context of the size of the project and the timeframe in which we implemented it. The challenges we have seen faced by the federal website and to varying degrees by virtually every state-based exchange are not surprising – in many ways, what is surprising is that we have nationally launched the set of new enrollment systems to enroll millions of consumers. Among the factors that we believe were important for Covered California's relative success are:

- The system requirements were defined and validated early with stakeholders, policymakers, project sponsors and potential vendors commenting on draft designs;
- Strong vendor selection, delegation and accountability mechanisms after the selection;

- Effective governance and oversight processes (with the joint control and decision-making of Covered California, the Department of Health Care Services and the state Office of Systems Integration
- Project team and Project sponsors stayed laser-focused on security issues and functionality needed for launch, which meant some functions deferred

But, relative success does not mean "perfect" – we have had challenges and continue to seek to build and improve the system as we go forward.

One of the central design elements of our system was to provide the best possible "user experience." Covered California and the Department of Health Care Services conducted extensive testing of potential designs to facilitate the determination of consumers' eligibility for financial assistance and then their selection of a health plan. These designs included conducting consumer testing and building a Spanish-language enrollment site that we made continuous improvements to over time. We also added printed applications in January in Spanish and several other key languages including, Chinese, Korean, Hmong, Vietnamese and Arabic.

As we launched the system, or primary focus was on security and core functionality. We conducted user-acceptance testing on all components and we have identified the need for many improvements that would enhance the consumer experience. We will continue to test the system and make upgrades.

With regard to assuring that our systems are safe and secure – Covered California has made the secure functioning of its data information systems, including the CalHEERS system, one of its top priorities. We are confident that the confidential information in these systems is protected as required by all federal and state laws. Consumers can be assured their data will be safely held and we have consistently put the security of consumers' information first. Examples include:

- CalHEERS incorporates and conforms to strict technical standards and requirements that include applicable provisions from the Federal Information Security Management Act (FISMA) of 2002, applicable publications developed by the National Institute of Standards and Technology (NIST), Federal Information Processing Standards (FIPS), Medicaid Information Technology Architecture (MITA) provisions and the Center for Medicare and Medicaid Services' Minimum Acceptable Risk Standards for Exchanges (MARS-E);
- Before we were given authority to connect to the federal data service hub by CMS, Covered California was required to complete and file (1) a systems security plan, (2) a safeguard procedures report, and (3) a security assessment report (SAR). In addition, the Internal Revenue Service (IRS) reviewed our plans and conducted an onsite visit to the Covered California data center before it gave Covered California authority to operate.
- Covered California continuously monitors the system to ensure our data systems remain compliant with all legal and security requirements. We run constant scans for DDOS (distributed denial of service) and audit the CalHEERS system to identify new threats or vulnerabilities. Without giving too much away, I can tell you that we audit

logs for review, conduct code review for any security-related defects and perform regular regression tests of each release to scan for any code that may introduce security leaks.

- In the event that a potential security breach occurs, the incident is sent to our Incident Review Board, which is a standing board that reviews every single case we receive. Our privacy officer then makes the determination where the incident gets reported.

Our enrollment isn't just about the online side of things. It's also about the people in communities across California and the familiar faces and trusted organizations in these neighborhoods that are helping people enroll.

Of the plans Covered California made, one element that did not play out the way we envisioned is enrolling them with a single contact — or a "one touch and done" approach. This may have been the case for some consumers, but we believe that for the vast majority — especially for those who are less familiar with insurance, and for non-English speakers this was not the case. Many people needed multiple touches before they understood their options and felt prepared to choose the plan that was right for them and their family. They needed in-person help from agents, certified counselors, county workers or Covered California's customer service staff to help them with their enrollment. These supports were vital to the next element of an exchange's success: effective enrollment.

We operate under a "no wrong door" approach, where consumers could apply online, over the phone, by mail or through one of our thousands of in-person enrollment specialists.

We have more than 5,400 Certified Enrollment Counselors, more than 10,000 county eligibility workers and nearly 12,000 Certified Insurance Agents who are providing free and confidential help. Add them up, and it's about 28,000 people who are certified to help consumers enroll. More than 5,000 of these Certified Enrollment Counselors and Certified Insurance Agents speak Spanish, and many speak other languages, including Mandarin, Cantonese, Korean, Hmong and Vietnamese, which is critical given California's rich diversity.

As part of being certified to provide consumers with enrollment assistance, all of those certified individuals go through an extensive training program and, for Certified Enrollment Counselors and our employees, we conducted background checks using the Department of Justice. Covered California's criminal background check process is consistent with other state agencies and based on the employer best practices as articulated in Title VII of the Civil Rights Act of 1964.

Covered California also supports enrollment through our three service centers, which are staffed by nearly 1,000 public employees. These employees, who either work for the State of California or through a contract with Contra Costa County, answer phone calls, process applications, and provide training and other support functions. Based on demand that far exceeded our expectations, we dramatically increased our service center staffing to provide

better customer service. We went from 469 trained service center representatives who were answering phones at the end of December, to 793 right now, which has helped us drop our wait times from nearly an hour to under 30 minutes. As of late March, more than 970,000 callers have been assisted by our customer service staff, with and average call "handle time" (time talking) of 20 minutes. We know that even with the increase in staff, the demand for service continues to drive wait times far beyond acceptable levels. In the coming months we will assess service levels and how to most cost effectively meet consumers' needs.

An example of a strategy that is already improving the customer service at our service centers is Integrated Voice Response technology. This technology allows consumers who call in to get recorded messages that may answer their questions while they wait to speak to a representative.

Covered California continues to make strides in improving our customer service, and we have done so while maintaining a constant eye on the costs of our financial plan. We know we don't have unlimited resources to hire thousands of operators to get those wait times down to zero, so we have tried to balance the needs of our customers with our budget.

EARLY LESSONS LEARNED

While we want to call out early observations, I want to caution anyone from jumping to any conclusions at this point. The dust has barely settled from the first open-enrollment period. If we were in a football game, we would still be in the first quarter.

California is one of 15 state-based exchanges. We share strategies, tactics and lessons on regular basis and we learn from one another. Based on those discussions and our experience, what follows are my early observations of elements that can contribute to the success of state-based exchanges:

- Leadership Focused on Consumers: Leaders and policy-makers in California have recognized that consumers are at the heart of the Affordable Care Act. Although, the law remains controversial, there is a broad consensus that it should be implemented in a manner that protects consumers and assures that they receive quality, affordable health care.
- Collaboration and Coordination of Key State and Local Agencies: We worked hand in hand with the California Department of Health Care Services, the California Department of Insurance, the California Department of Managed Health Care, counties and others to establish clear roles and governance.
- Key Stakeholder Engagement: We partnered with health plans, insurance agents, chambers of commerce, technology firms, marketing and communications

companies, leaders from the entertainment industry and social media, health care advocates, unions and advocacy organizations, community-based organizations, philanthropic groups, doctors, nurses, community clinics, medical groups and hospitals. Together these organizations have played a vital role, not only on the enrollment and education front, but also ensuring that all those who enroll get needed care.

- Maintain Flexibility: We remained nimble in our efforts when needed to achieve our goals. We switched our marketing focus and outreach efforts in the middle of open enrollment. We created new advertising material and made additional focused ad buys to reach California's Latino and African-American communities. We partnered with civil rights icon Dolores Huerta and used Cesar Chavez's birthday as an anchor for organizing throughout the state and continuing the substantial efforts that had been started earlier.
- Commitment to Transparency and Learning: Above all else, we have been committed to being transparent and engaged with our partners and the public. A key example of this was during the construction of CalHEERS, when we released a draft request for proposal and then revised it based on input from vendors and advocates.

Thank you for having me here this morning. The Affordable Care Act is making fundamental changes to our health care system and improving the lives of millions of people. This new era of health care has already provided life-saving treatments for some, has changed lives for others and has given people the priceless peace of mind and security that they deserve.

We are grateful for your support for this historic effort to ensure more Americans have access to the quality, affordable health care they need and deserve.

I look forward to answering your questions and doing whatever we can at Covered California to help the Affordable Care Act succeed in our state and across the country.

Mr. JORDAN. Thank you, Mr. Lee.
Mr. Leitz, you are up for your five minutes.

STATEMENT OF SCOTT LEITZ

Mr. LEITZ. Chairman Jordan, Chairman Lankford, Chairman Issa, Ranking Member Speier, Ranking Member Cartwright, Ranking Member Cummings, and members of the Oversight and Government Reform Committee, good morning. Thank you for inviting me to come here today to talk about Minnesota's experiences in establishing MNsure, our online health exchange.

I want to start by telling you about Corey and Kate Needleman, who live in Minneapolis. Corey is a teacher. For years the family had health insurance through his job. But over time the family's out-of-pocket costs grew. After welcoming their third son, Irving, into the family, they had to choose between paying their mortgage or paying their health bills. Last fall, when MNsure opened, her three boys qualified for medical assistance with no premium or deductible, and she was able to purchase a plan for herself that is less than $200 a month without tax credits. In her words, I was thrilled. It blows my mind that we are going to be able to be cared for and we are not going to lose our house.

Today, I am proud to say MNsure is stable, secure, and successful; and, because of our efforts, the Needlemans are just a few of the nearly 170,000 people in Minnesota who now have access to affordable, comprehensive coverage because of MNsure.

Of that 170,000, nearly 88,000 have enrolled in Medicaid, over 34,000 have enrolled in MinnesotaCare, our State's basic health plan for people between 133 and 200 percent of the Federal poverty line. In other States, these individuals or enrollees would be in private plans with tax credits. The remaining over 47,000 have enrolled in private qualified health plans.

It is also worth nothing that in Minnesota 95 percent of the people enrolled in health coverage have paid for it. And as we continue to process applications, we expect our numbers to grow even higher.

It isn't news to this committee that MNsure's rollout was rocky. Our initial launch in October was plagued by software errors and technical glitches. I was appointed interim chief executive officer on December 18th, after the resignation of MNsure's first executive director. In recognition that more must be done to ensure Minnesotans have access to a functioning Website and comprehensive affordable health coverage, I took immediate action. In January I commissioned an end-to-end review of our exchange by Optum Health. They recommended we make a number of enhancements to customer experience to help boost enrollment and to improve customer satisfaction.

Working in close partnership with our vendors, we were able to stabilize our system. Our eligibility software is now operating with an over 99 percent success rate, compared to 70 percent in mid-December, and our online marketplace has been stable enough to process more than 2,000 enrollments a day.

December's software problems caused our call center wait times to climb to over an hour, and up to 70 percent of consumers were simply giving up before they could be helped. We resolved this

issue by more than doubling the size of our call center and by bringing stability to our software system. Average wait times for the month of March were dramatically less.

Moving forward, we are planning our budgets for 2015. I am happy to say that next year's calendar year budget is balanced and does not seek additional State or Federal funds to operate MNsure.

In the longer term, we are in the process of selecting a lead vendor that will help MNsure assess the larger architectural software issues that were identified in the Optum report. The goal is to not just make the 2015 open enrollment period a better experience for consumers, but to have a comprehensive roadmap for continuously improving MNsure and enhancing the exchange for consumers in every open enrollment period to come.

I had the opportunity to meet Kate Needleman and her son Irving recently. She told me that having affordable insurance has opened the door for her family. Health reform is indeed more than a Website; it is about getting real people and families into affordable comprehensive health coverage. This is something we are doing well in Minnesota.

Thank you for the opportunity to testify, and I look forward to your questions.

[Prepared statement of Mr. Leitz follows:]

Testimony of Scott Leitz, Interim CEO, MNsure
U.S. House of Representatives Oversight and Government Reform Committee,
Subcommittees on Economic Growth, Job Creation and Regulatory Affairs
and Energy Policy, Health Care and Entitlements

April 3, 2014

Thank you for inviting me to come here today to talk about Minnesota's experiences in establishing MNsure, our online health exchange.

I want to start by telling you about Corey and Kate Needleman who live in Minneapolis. Corey is a teacher. For years the family had health insurance through his job. But over time the families out of pocket costs grew. After welcoming their third son, Irving, into the family, they had to choose between paying their mortgage or paying their health bills. Last fall, when MNsure opened, her three boys qualified for Medical Assistance with no premium or deductible, and she was able to purchase a plan for herself that is less than $200 a month - without tax credits. In her words, "I was thrilled. It blows my mind that we are going to be cared for and we are not going to lose our house."

Today, I am proud to say MNsure is stable, secure and successful. And because of our efforts, the Needlemans are just a few of 169,005 people in Minnesota who now have access to affordable, comprehensive coverage because of MNsure.

Of that 169,005:

- 87,986 have enrolled in Medicaid under the expanded provisions of the Affordable Care Act
- 34,219 have enrolled in MinnesotaCare, our state's basic health care plan for people between 133 and 200 percent of the federal poverty line. In other states, these enrollees would be in private plans with tax credits.
- The remaining 46,800 have enrolled in private Qualified Health Plans.

It is worth noting that in Minnesota, 95% of people enrolled in health coverage have paid for it. And as we continue to process applications, we expect our numbers to grow even higher.

It isn't news to this committee that MNsure's rollout was rocky. Our initial launch in October was plagued by software errors and technical glitches that ultimately resulted in the resignation of MNsure's first executive director. I was appointed Interim Chief Executive Officer on December 18.

In recognition that more must be done to ensure Minnesotans have access to a functioning website and comprehensive, affordable health coverage, I took immediate action.

In January, I commissioned an end to end review of our exchange by Optum Health. They recommended we make a number of enhancements to the customer experience to help boost enrollment and customer satisfaction.

Working in close partnership with our vendors we were able to stabilize our system. Our eligibility software is now operating with an over 99 percent success rate, compared to 70% in mid-December. And our online marketplace has been stable enough to process more than 2,000 enrollments a day.

December's software problems caused our call center wait times to climb to over an hour and up to 70 percent of consumers were simply giving up before they could be helped. We resolved this problem by more than doubling the size of our call center and by bringing stability to our software system. Average wait times for the month of March were dramatically less.

Moving forward, we are planning preliminary budgets for 2015. I am happy to say that next year's calendar year budget is balanced and does not seek additional state or federal funds to operate MNsure.

In the longer term, we are in the process of selecting a "lead vendor" that will help MNsure assess the larger architectural software issues that were identified in the Optum report. The goal is to not just make the 2015 open enrollment period a better experience for consumers, but to have a comprehensive roadmap for continuously improving MNsure and enhancing the exchange for consumers in every open enrollment period to come.

Last week, I had the opportunity to meet Kate Needleman and her son Irving at an event. There she told me that, 'Having affordable insurance has opened a door for her family.' The affordable care act is more than a website. It's about getting real people and families in to affordable, comprehensive health coverage. This is something we are doing well in Minnesota.

Mr. JORDAN. Thank you, Mr. Leitz.

Mr. Van Pelt, you have been patiently waiting. You are up.

STATEMENT OF GREG VAN PELT

Mr. VAN PELT. Thank you very much. Mr. Chairman, ranking members, and other members of the Oversight and Government Reform Committee, thank you for allowing me to speak before you today about Oregon's health reform efforts. My name is Greg Van Pelt. I recently retired as chief executive officer of Providence Health and Services in the Oregon region. Throughout my career I have had direct experiences with the challenges of expanding access to quality health care while managing costs.

Last year, Governor Kitzhaber asked me to step in to help navigate the challenges around the launch of the State's health care exchange. Currently, I serve as the president of the Oregon Health Leadership Council and voluntary advisor to the governor and Dr. Bruce Goldberg, acting director of Cover Oregon, for whom I am appearing today because he recently suffered a broken leg.

While the launch of the ACA in Oregon has been different than we hoped, over 300,000 individuals have enrolled in health insurance plans since October 1st. Governor Kitzhaber, two weeks ago, released an independent assessment of Cover Oregon produced by the company First Data. The report, which I also request to be included in today's record, was based on 67 interviews with stakeholders from Cover Oregon and Oregon Health Authority employees to the governor and legislators from both sides of the aisle and a review of more than 3,200 documents. It assesses the technical problems with the development and rollout of our health exchange Website.

Members of the committee, I want you to know that in response to First Data's findings, the governor announced numerous steps he has taken or will take to improve performance, accountability, and oversight. These steps are detailed in my written testimony, which also has been shared with you.

We do know that some things have worked very well. We have used our technology investment to roll more than 300,000 Oregonians in health care coverage since October thanks to Cover Oregon and the Oregon Health Authority. We continue to be proud of the work we have done to improve Oregonians' lives, and we know that that will endure.

I welcome your questions and the opportunity to discuss with you Oregon's ongoing health care transformation work, as well as the progress that we have made to secure the public trust to make good on Cover Oregon's promise to enroll more Oregonians in affordable, high-quality health insurance. Thank you very much.

[Prepared statement of Mr. Van Pelt follows:]

Testimony of

Greg Van Pelt,

President, Oregon Health Leadership Council

Advisor to Governor John Kitzhaber, MD, and Acting Executive Director of Cover Oregon Dr. Bruce Goldberg

for the Subcommittees on Economic Growth, Job Creation, and Regulatory Affairs; and, Energy Policy, Health Care, and Entitlements of the U.S. House of Representatives Oversight and Government Reform Committee

April 3, 2014

Good morning. Chairman Jordan, Chairman Lankford, Ranking Member Speier, Ranking Member Cartwright, and other members of the Oversight and Government Reform Committee, thank you for allowing me to speak before you today about Oregon's health reform efforts.

My name is Greg Van Pelt. I recently retired as Chief Executive Office of Providence Health in the Oregon region. Throughout my career I have had direct experience with the challenges of expanding access to quality health care while managing costs. Last year Governor Kitzhaber asked me to step in to help navigate the challenges around the launch of the state's health care exchange. Currently, I serve as the president of the Oregon Health Leadership Council. I also volunteer as an advisor to the Governor and Dr. Bruce Goldberg, Acting Director of Cover Oregon, for whom I am appearing today because he recently suffered a broken leg.

As we know, the fundamental problem in our health care system is the huge and rapidly growing discrepancy between the cost of health care and the resources available to pay for it and the fact, for all our health care-related expenditures, the poor population health statistics that result from this huge outlay of resources.

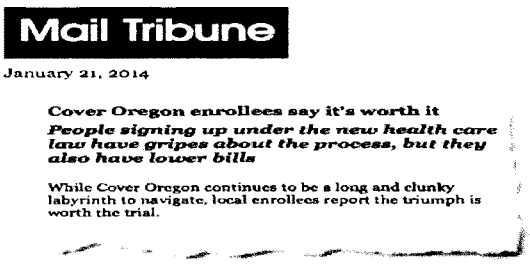
Three strategies have traditionally been employed by both public and private payers to address these problems: reducing what we pay for health care (cutting provider reimbursement); reducing

the number of people covered; and/or reducing the covered benefits. The first two strategies – cutting provider reimbursement rate and reducing the number of people who are covered – simply create barriers to access, leading people to delay seeking needed medical care and eventually driving many of them into the emergency department.

And while both strategies allow public and private payers to reduce their short-term exposure to medical inflation, they also serve as a kind of "pressure valve" that allows us to avoid confronting the real underlying problem, which is the cost of health care itself. As a result, neither of these strategies is effective because the uncompensated costs incurred by the uninsured or underinsured are simply shifted back to payers and reflected in increased premiums.

Unless our efforts at health care reform can break this cost-shifting cycle, we will not succeed in the long run. This is why all of our efforts in Oregon have been focused on improving health, improving care, and lowering the cost of care. Through this vision, we are fundamentally changing how care is delivered as we provide coverage for hundreds of thousands Oregonians, many of whom are receiving preventative care and wellness services for the first time.

Yet, the launch of the Oregon's insurance exchange has been different than we hoped. As a result, Governor Kitzhaber took two important actions. He launched a hybrid electronic and paper application process using the pieces of the IT infrastructure that work, to ensure Oregonians could enroll. He also initiated an independent review to identify the problems that led to the broken website and the necessary steps to deliver on the state's goal to get Oregonians the health coverage they need.



Mail Tribune

January 21, 2014

Cover Oregon enrollees say it's worth it

People signing up under the new health care law have gripes about the process, but they also have lower bills

While Cover Oregon continues to be a long and clunky labyrinth to navigate, local enrollees report the triumph is worth the trial.

Governor Kitzhaber two weeks ago released the results of the independent assessment of Cover Oregon produced by the company First Data. The report was based on 67 interviews with stakeholders – from Cover Oregon and Oregon Health Authority employees, to the Governor and legislators from both sides of the aisle – and the review of more than 3,200 documents. It assesses the technical problems with the development and rollout our health insurance exchange website.

First Data's key findings focus on Cover Oregon's project management structure, communication issues, the lack of a system integrator, and contracting practices. The report also highlights the deficiencies of Oracle, which was hired as the primary website developer. First Data's assessment of Oracle reinforces a report completed in February by the Centers for Medicare and Medicaid Services. In March, the state announced that it is transitioning away from Oracle while maintaining its objective to enroll Oregonians in health care plans through the open enrollment period.

Members of the Committee, the Governor announced numerous steps he has taken or will take to improve performance, accountability, and oversight.

- The Governor signed into law three bills that were passed by the Oregon State Legislature in February 2014 to increase the accountability, oversight, and transparency of state technology investments; strengthen oversight of Cover Oregon; and seek additional assistance for those who have had problems enrolling in health care coverage.

- Governor Kitzhaber has directed the Oregon Department of Administrative Services to inventory all IT projects currently underway in the Executive branch. The inventory is the first step toward tracking IT-related investments and activities through a statewide portfolio. IT projects across all state agencies will be evaluated and monitored to help identify and resolve issues and improve communication and coordination.

- The Governor has written to Senators Ron Wyden and Jeff Merkley requesting that the pending review by the Government Accountability Office include a thorough appraisal of

Oracle's inability to properly estimate the amount of work necessary to complete the project, deliver on key deadlines, and adhere to industry standards. He also asked that the different risk status ratings of the project reported internally and externally be reviewed.

- Moreover, the Governor has met with Oregon Attorney General Ellen Rosenblum, who has received a copy of the First Data report. Lawyers for the State and Cover Oregon are reviewing the report along with additional information. They will consider the full range of legal avenues and options for protecting the state's investment and evaluating the work performed by Oracle and other technology vendors under contracts with the state.

- Governor Kitzhaber convened a team of information technology experts to advise Cover Oregon on IT options going forward. The team includes the Chief Information Officers of Legacy Health, Pacific Source, Kaiser Permanente, Providence, Moda, Bridgespan/Regence, and Oregon's Chief Information Officer, Alex Petit. Beyond that, Alex this week began serving as the Interim CIO at Cover Oregon.

- You may be aware that the Governor accepted Dr. Goldberg's resignation as Director of the Oregon Health Authority. Dr. Goldberg will continue his role as Acting Director of Cover Oregon until the new executive director is hired. Dr. George Brown, President and CEO of Legacy Health, and a Cover Oregon board member, is overseeing the search process for the new executive director.

- In addition to asking the Cover Oregon Board to change the top technology and operational leadership at the insurance exchange, our Governor requested the Board undertake a full assessment of Cover Oregon's current structure, staffing model, and governance.

- Last week, Governor Kitzhaber announced an agreement between Cover Oregon and participating insurance companies that will help small businesses access federal tax credits. Qualified small businesses that purchase a Cover Oregon-certified plan after

April 1st directly from an insurance company will be able to access tax credits for 2014. This is crucial for our small businesses and the Oregonians they employ. It is also evidence of the good working relationships that Cover Oregon has cultivated with participating insurance companies.

While all of the aforementioned steps are moving forward, Oregon is helping people access health insurance coverage and improving the care they receive once they are covered.

Governor Kitzhaber's goal is to ensure that every Oregonian who needs insurance coverage has the opportunity to enroll through Cover Oregon or directly with a health plan. To help meet this goal, and in light of the challenges with the Cover Oregon website, he called for an extended application period through April 30th. Oregonians are able to apply for coverage this month. At the same time, the Governor is committed to ensuring that the problems we have experienced with the website do not happen again. He made it plain that we must learn from this project and adopt whatever changes are necessary to improve project management and safeguard public investments in the future.

Members of the Committee, experience tells us that successful businesses develop as the result of a business model and an investment environment that fosters growth and prosperity. For decades the U.S. health care system has been built around a business model that assumes that the government and private employers will unquestioningly underwrite a medical inflation rate that grows much faster than the CPI; and that this system will continue to be financed notwithstanding the increasingly tenuous relationship between cost and improved health.

In June 2011, Oregon took the first step to develop a new business model with the passage of two significant pieces of legislation. The first, House Bill 3650, was an acknowledgement that we needed a new businesses model to transform our health care system.

This business model was built around the "coordinated care organizations" or CCOs – new, local delivery entities formed around "natural communities of care" like counties or hospital referral

areas. Each CCO would be unique and might look different in different parts of the state, but all would reflect six key elements:

1. Best practices to manage and coordinate care
2. Sharing responsibility for health between providers and consumers
3. Measuring performance
4. Paying for outcomes and health
5. Providing actionable information
6. Financially sustainable per member rate of growth

It is worth noting that this legislation – as well as the legislation establishing our state health insurance exchange – passed with overwhelming bipartisan majorities. Further, our health transformation initiative has been supported by all of Oregon's major business organizations, by our largest companies, including Nike and Intel, by the small business community, and by AFL-CIO, SEIU, health care providers, and consumer advocates. Instead of using the crisis in our health care system as a political football, Oregon moved forward with clear goals and an intention to deliver better results for people across the state.

Oregon, in partnership with the Administration, has committed to reduce the Medicaid inflation trend by two percentage points per capita to 3.5 percent by the end of this year and to lock this rate going forward. This cost reduction will save both the federal and state government $4.9 billion over 10 years while improving the quality of care delivered to Oregonians.

Oregon's coordinated care organizations are starting to show results in containing costs, reducing unnecessary emergency department visits and increasing primary care. As we bring more than 230,000 new enrollees into Medicaid, these strategies will help offset increased utilization in many areas and help local providers manage the increased demand for services. And patients will receive better care.

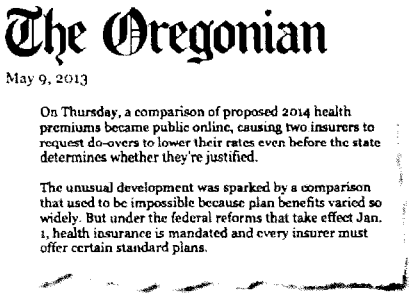
If we can successfully implement what we are proving out in our Medicaid program to state employees, teachers, qualified health plans on the exchange, and private businesses, it will have

profound effects. Private business could save valuable resources to allow their businesses to grow. Local and state government can save precious resources or invest in critical areas like education, early learning, and public safety, to name a few.

In the years to come, our state will look fundamentally different than it does today for the simple reason that we have ended one of the most glaring inequities of our time; the era of the haves and have-nots when it comes to health insurance is over.

More than 300,000 Oregonians have enrolled in health care coverage since October thanks to Cover Oregon and the Oregon Health Authority.

We know that some things have worked well. We have a successful health insurance market. Eleven health insurance carriers and nine dental plans are participating in our exchange. There are more than 100 choices of health and dental plans. Competition between those carriers has helped to save Oregon families money by driving down premiums. In fact, a few of those carriers actually asked to reduce their premiums last year to ensure their competitiveness on the open market.



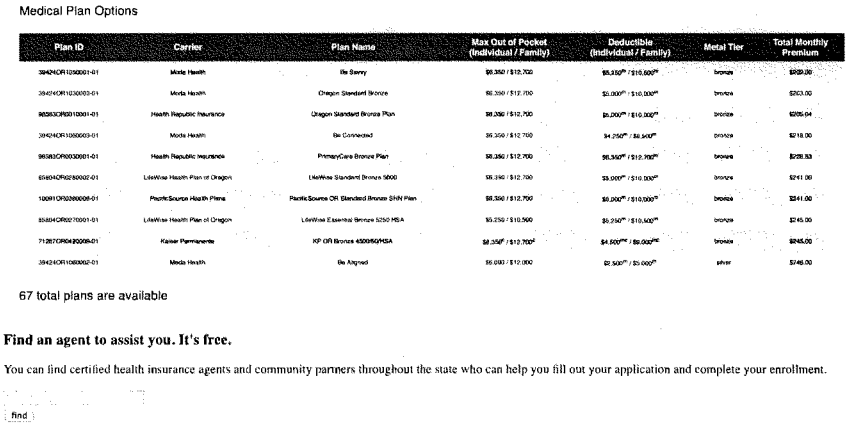
The Oregonian

May 9, 2013

On Thursday, a comparison of proposed 2014 health premiums became public online, causing two insurers to request do-overs to lower their rates even before the state determines whether they're justified.

The unusual development was sparked by a comparison that used to be impossible because plan benefits varied so widely. But under the federal reforms that take effect Jan. 1, health insurance is mandated and every insurer must offer certain standard plans.

The launch of Cover Oregon only reinforces this by allowing consumers to compare and shop for plans. As a result of this new transparency, for the first time, people can compare plans side by side. Oregonians can shop online and compare all available plans. We have a single place where individuals can be determined eligible for either private commercial coverage or Medicaid.



Medical Plan Options

Plan ID	Carrier	Plan Name	Max Out of Pocket (Individual / Family)	Deductible (Individual / Family)	Metal Tier	Total Monthly Premium
39424OR1290001-01	Moda Health	Be Savvy	$6,350 / $12,700	$6,350[1] / $10,500[2]	bronze	$269.20
39424OR1030003-01	Moda Health	Oregon Standard Bronze	$6,350 / $12,700	$5,000[1] / $10,000[2]	bronze	$263.00
96583OR0910001-01	Health Republic Insurance	Oregon Standard Bronze Plan	$6,350 / $12,700	$5,250[1] / $10,500[2]	bronze	$205.04
39424OR1060003-01	Moda Health	Be Connected	$6,350 / $12,700	$4,250[1] / $8,500[2]	bronze	$218.00
96583OR0930001-01	Health Republic Insurance	PrimaryCare Bronze Plan	$6,350 / $12,700	$6,350[1] / $12,700[2]	bronze	$238.53
69845OR0280002-01	LifeWise Health Plan of Oregon	LifeWise Standard Bronze 5000	$6,350 / $12,700	$5,000[1] / $10,000[2]	bronze	$241.00
10081OR0280006-01	PacificSource Health Plans	PacificSource OR Standard Bronze 5000 HSA Plan	$6,350 / $12,700	$5,000[1] / $10,000[2]	bronze	$241.00
69845OR0270001-01	LifeWise Health Plan of Oregon	LifeWise Essential Bronze 5250 HSA	$6,250 / $10,500	$5,250[1] / $10,500[2]	bronze	$245.00
71267OR0490006-01	Kaiser Permanente	KP OR Bronze 4500/60/HSA	$6,350[1] / $12,700[2]	$4,500[1][3] / $9,000[2][3]	bronze	$245.00
39424OR1060002-01	Moda Health	Be Aligned	$6,000 / $12,000	$2,500[1] / $5,000[2]	silver	$746.00

67 total plans are available

Find an agent to assist you. It's free.

You can find certified health insurance agents and community partners throughout the state who can help you fill out your application and complete your enrollment.

find

Example

Consumers in Oregon can enroll online. But the website is only partially functioning. The process is only seamless for those who seek to enroll through agents and community partners. Individuals browsing and applying on their own will not be able to fully enroll in one sitting.

In short, applying and enrolling is not as easy as it will be in the future. But here is what we also know. More than 175,000 enrollments have been completed – over 55,000 for commercial coverage and 120,000 for Medicaid through our state-based market. An additional 125,000 people have enrolled in Medicaid directly through our Medicaid program. Those numbers grow every day.

This will change our state in ways we don't understand yet. Everyone from the homeless woman sleeping on the streets of Portland, to the rancher in Ontario, to the freelance designer with a

preexisting condition in Astoria, can get comprehensive health care coverage that includes preventive care and health screenings, prescription coverage, and mental health care. Every Oregonian now has the same chance for health.

Oregonians have more options than they had in the past. When they gain health insurance, their medical debt goes down. Families are not facing bankruptcy due to medical bills and providers do not have hundreds of thousands of dollars of unpaid debt. The reality of our former insurance system was that people got underwritten out and were forced into expensive high-risk plans. Now everyone pays the same price, everyone has the same option for coverage. That is what the Affordable Care Act means in our state.

Oregon is committed to health care reform that delivers better health, better care, and lower costs. We have begun that work in our Medicaid program and have enrolled hundreds of thousands Oregonians into quality, affordable health insurance. Our private health insurance market is competitive, transparent and saving families money while providing health and economic security. In time, our problems with our website will be resolved. We continue to be proud of the work we have done to improve Oregonians lives. We know that will endure.

I welcome your questions and the opportunity to discuss with you Oregon's ongoing health care transformation work, as well as the progress that we have made to secure the public trust and to make good on Cover Oregon's promise to enroll more Oregonians in affordable, high-quality health insurance.

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Mr. JORDAN. Thank you, Mr. Van Pelt.

We will now turn to questioning. We will start with the gentleman, the vice chair of the committee, Mr. Gosar, the gentleman from Arizona.

Mr. GOSAR. Well, thank you very, very much.

Mr. Leitz, I want to start off with you. You talked about the rocky start for your exchange earlier. So my first question is, in the three months leading up to the botched Website rollout, 14 managers of the sites received bonuses for work they did on the exchange. Is that accurate?

Mr. LEITZ. Congressman, it is.

Mr. GOSAR. Now, why would the State pay people a total of $27,000 for a botched Website? Usually, bonuses go to exceptional work. Botched doesn't seem to meet exceptional.

Mr. LEITZ. Congressman, those bonuses were approved by the previous executive director.

Mr. GOSAR. Oh, I am glad you said that because have you done anything to claw back those bonuses?

Mr. LEITZ. Congressman, not to date, no.

Mr. GOSAR. Interesting. Now, in January, United Health's Optimum division released a report stating that the exchange's current program management structure and process is nonexistent, and management leadership decision-making is occurring via crisis mode. That report also concluded that the exchange might be so badly flawed that MNsure might have to scrap all of it. In the same article you were quoted as saying, we do intend to take actions—in fact, I thought I heard you speak about this in your comments—we intend to take actions as result of the report.

Have you fired anyone in the State government for the bungled launch and the massive loss of taxpayer dollars?

Mr. LEITZ. Congressman, we have made changes within the organization.

Mr. GOSAR. I asked you a question. Have you fired anybody for——

Mr. LEITZ. Congressman, personnel actions have been taken.

Mr. GOSAR. People have been fired?

Mr. LEITZ. Congressman, I am not——

Mr. GOSAR. Or they have just been reassigned, like here in the Federal Government, and given a new title?

Mr. LEITZ. Congressman, individuals are no longer with the organization who previously had been.

Mr. GOSAR. Are they still in the State government?

Mr. LEITZ. Congressman, no.

Mr. GOSAR. So you did make some changes.

Mr. LEITZ. Yes, Congressman.

Mr. GOSAR. Now, last week the Los Angeles Times reported on how Governor Dayton referred to the Minnesota exchange as the black hole, where he was referencing consumer applications that were frozen or had vanished. Did you ever find out where those vanished applications went?

Mr. LEITZ. Congressman, yes, we did.

Mr. GOSAR. You have a total accounting of all those vanished?

Mr. LEITZ. Congressman, yes, we are able to identify any applications that had previously been in the system that we weren't able to track during the fall rollout.

Mr. GOSAR. Will you provide that to the committee? I mean, a lot of the folks back in Minnesota don't know that story.

Mr. LEITZ. Congressman, I would be very happy to provide an accounting of those individuals, in the aggregate, of course.

Mr. GOSAR. Thank you very much.

Now I am going to go to everybody, so we are going to try to go fairly quickly. How many people did you have to hire to process paper applications because of the problems with your exchange Website? Start with you, Dr. Matsuda.

Mr. MATSUDA. In our contact center, recently we increased staffing to handle the backlog that I mentioned in my remarks by a total of 80 people.

Mr. GOSAR. How much did that cost?

Mr. MATSUDA. I will have to supplement that to the record. I can get the exact number for you.

Mr. GOSAR. We would like to know how it was paid for, too.

So let's go to the next. Mr. Sharfstein?

Dr. SHARFSTEIN. About 200 more people through the call center and fulfillment center, about $6 million.

Mr. GOSAR. And how was it paid for?

Dr. SHARFSTEIN. Through our grants through the usual rules.

Mr. GOSAR. Through the Federal Government?

Dr. SHARFSTEIN. Federal and State government, right.

Mr. GOSAR. Okay.

Ms. Yang?

Ms. YANG. Congressman, we have leveraged the workforce of about 300 individuals through an intensive work period in the past four weeks, and we are happy to report that the paper application backlog has been eliminated.

Mr. GOSAR. And how much did it cost?

Ms. YANG. I do not know the precise number for that period. We can get back to you on that.

Mr. GOSAR. And how it was paid for.

Mr. Lee?

Mr. LEE. We have a customer service staff that we expanded by about 250 people that do both phone and mail, but we also have shared into the paper processing work with county partners throughout the State of California and additionally did some extra contracting of vendors to help us get through the paper backlog. I am not sure the exact number; I will happily follow up with you on that number, but it was absolutely paid for out of our Federal establishment grants.

Mr. GOSAR. Okay.

Mr. Leitz?

Mr. LEITZ. Congressman, approximately 50 individuals were added for that purpose. We also paid for that out of the establishment grant.

Mr. GOSAR. Gotcha.

Mr. Van Pelt?

Mr. VAN PELT. Thank you. Oregon also leveraged workforce from different State agencies, but I will have to get back to you on the precise number and payment source.

Mr. GOSAR. I am going to come right back to you real quickly, Mr. Van Pelt, because when did the State first alert CMS that the exchange was not going to be operational?

Mr. VAN PELT. That is all in the first data assessment, and I would have to defer to that report, congressman.

Mr. GOSAR. So you can't address the oversight?

Mr. VAN PELT. My particular role was such that I was called in shortly after the governor and the Cover Oregon determined that this was not working or going to work, and, that being the case, my time focused on setting up the paper application process and steps going forward.

Mr. GOSAR. And my point was that CMS had very, very poor oversight. In fact, your predecessors were talking in regards to their lackluster questions and how they had impressed CMS with unimpressive answers. So I would like to have a detailed report on that.

Mr. VAN PELT. Be happy to do that.

Mr. GOSAR. I yield back.

Mr. JORDAN. I thank the gentleman.

Gentlelady from California, the ranking member, is recognized.

Ms. SPEIER. Mr. Chairman, thank you.

And thank you again for your really outstanding testimony. It is really a tribute to you as executives in each of your programs that you have turned lemons into lemonade.

I would like to start by quoting the speaker when he referenced the rollout as horrendous and a launch was anything but smooth. Representative Barton called it a huge undertaking and there is going to be glitches.

Now, those were comments made by the speaker and by Congressman Barton on the rollout of Part D, Medicare Part D, which was seen as full of problems with the initial rollout; and, yet, Republicans at that time were all about fixing it because it was in President Bush's Administration. I would like to see the same kind of frankness and willingness to fix the system now that it is in President Obama's Administration and we are undertaking a much, much larger effort.

Now, what is good about everything I have heard here this morning is that you have fixed the initial problems. You are all optimistic about the success of your programs. Can I just have each of you indicate whether or not you believe that you have met your goals or will meet your goals?

Mr. MATSUDA. Thank you, Ms. Speier. We do believe we are going to reach our goals. Our system is working, as I testified earlier, and, really, our goal now for the short-term is to improve the functionality and the usability of our system.

Dr. SHARFSTEIN. Maryland has exceeded its enrollment goal.

Ms. SPEIER. Ms. Yang?

Ms. YANG. Congresswoman, as you have heard in my testimony, we are proud of the fact that we are achieving the fundamental goal of the ACA, which is expand coverage on top of an already

solid ground on Massachusetts. Our work is not done, but we are on a very solid path.

Ms. SPEIER. Mr. Lee?

Mr. LEE. Well, we actually have never had specific goals. We have exceeded all expectations and all independent projections. Our goals are to insure every single Californian, so we still have work to do.

Ms. SPEIER. Mr. Leitz?

Mr. LEITZ. Congresswoman, Minnesota is solidly on track and we feel very good about the future of what is ahead of us.

Ms. SPEIER. Mr. Van Pelt?

Mr. VAN PELT. Thank you. Oregon is very much on its way to achieving its enrollment goals and feels confident in the steps we have taken to improve our technology.

Ms. SPEIER. Great.

Mr. Lee, California is a great sunshine story here and we are proud of that. Would you tell us what some of the reasons for the success were?

Mr. LEE. Congresswoman, I would be happy to, and some of these are highlighted in my testimony, and I would highlight just very briefly five things.

One, leadership across the State focused on consumers. We put politics aside and said let's make this work for consumers.

We had very effective collaboration both between State agencies, the Medi-Cal agency, which I partner with, but also with the regulatory agencies; Department of Managed Health Care, Department of Insurance. This has changed the entire insurance market. It is not just about exchanges, it is about changing the marketplace. That coordination is critical.

Partnerships. This has worked because it has worked on the ground in communities, with community clinics, with counties, with insurance agents. That partnership collaboration has been vital.

Finally, that we have had a culture of both transparency and learning. We have had bumps along the way, and we have adjusted our course continually, and will continue to do that. This is the beginning of a very long road and we look forward to learning and improving as we go forward.

Ms. SPEIER. Dr. Sharfstein, you are going to implement the Connecticut IT solution. I don't know how many other States are, but they seem to have made it work very well. What do you think the key is to the Connecticut system?

Dr. SHARFSTEIN. Thank you, Congresswoman. There are several things that are very attractive about the Connecticut solution. First of all, it is a very simple and elegant design both for consumers and the consumer assistance workers. It also has very good functionality for insurance brokers, and we have a lot of insurance brokers that we are working with in Maryland, so that was very good. It also uses some of the same software, not the specific software for the Affordable Health Care Act, but some of the general software pieces that we already have licenses to, and it runs on the same kinds of computers that we have already purchased. So there is a lot of overlap and allows us to reuse some of the initial investment.

So those are some of the reasons. And we were able to demonstrate it at our board meeting recently. We have gotten a lot of positive feedback around Maryland for that.

Ms. SPEIER. All right. Thank you all.

Mr. JORDAN. We will now go to the gentleman from Michigan, Mr. Walberg.

Mr. WALBERG. Thank you, Mr. Chairman, and thank you for holding this hearing to look at a program that is being panned as just an exceptional opportunity to, I guess, carry on an approach that takes away freedom, competition, opportunity, and I think great health care continuation for our Country simply because we are unwilling to deal with the costs and increase that competition.

But let me ask a question of Mr. Lee. Thank you for being here. A July 2013 State auditor's report that called the Covered California plan a new high-risk entity. That was the auditor's statement. The report stated that under all enrollment scenarios Covered California will not have sufficient revenue to cover its operating costs in fiscal year 2015–2016. Specifically, it said it would be losing $73 million. You told State finance officials in September that "the long-term sustainability of the organization" is its greatest weakness.

What did you mean by that?

Mr. LEE. Well, a couple things. One, we are very appreciative to receive Federal funding to get going. In California, after we are going, we will be running 100 percent on our own steam, supported by premium dollars. We, by State law, cannot go to the State of California for general funds, so making sure we are fiscally well managed is a critical important factor for being an ongoing organization.

The auditor's report also noted, I believe, and our budgeting has always planned to have a couple years of what are called deficit spending to then be operating in the black. In 2016–2017, we plan to be operating in the black and put money in the bank——

Mr. WALBERG. You still believe that you will be?

Mr. LEE. Pardon me?

Mr. WALBERG. You still believe that you will be operating in the black?

Mr. LEE. Absolutely. Absolutely. We are actually in the process of developing our next year revised budget now based on our current enrollment figures that we will be taking in draft to our board actually this next month, and we will be able to adjust every year our operations both on the revenue and the expense side to be fiscally well managed for Californians.

Mr. WALBERG. Well, let me follow up that with, again, the State auditor's report noted that premiums in both the individual and SHOP markets "generally would provide the revenue required to operate the exchange."

Mr. LEE. That is right.

Mr. WALBERG. But you shut down the SHOP market earlier this year.

Mr. LEE. No, we did not, Congressman.

Mr. WALBERG. You didn't shut it down?

Mr. LEE. Absolutely not. Our SHOP market is running. We have more than 6,000 individuals enrolled and over 600 businesses. We

turned off the online enrollment functionality, which is generally not used——

Mr. WALBERG. Of the SHOP market.

Mr. LEE. Of the SHOP market. But that is generally not how small businesses enroll anyway, using online functionality. But we are enrolling people today and continue to in our SHOP program.

Mr. WALBERG. So you don't plan any taxpayer bailout in the future?

Mr. LEE. Absolutely not.

Mr. WALBERG. You are certain of that?

Mr. LEE. By State law, in California, I want to be clear, we cannot be dependent on general fund money, and we expect that we are going to be converting to——

Mr. WALBERG. Federal taxpayer bailout as well?

Mr. LEE. We have been supported by the Federal support to get launched.

Mr. WALBERG. But you don't expect any more Federal support or bailout.

Mr. LEE. I do not expect any more.

Mr. WALBERG. We will hold you to that.

Mr. LEE. Okay.

Mr. WALBERG. I hope that is the case.

Mr. LEE. Me too, Congressman.

Mr. WALBERG. We both do.

Let me move on to ask several of you questions.

Let me start with Dr. Sharfstein. In total, how much has been paid to your State to develop and operate its exchange?

Dr. SHARFSTEIN. So far, our exchange has spent, for all costs, including the website, about $129 million.

Mr. WALBERG. That is what has been paid in total to your State to operate this exchange?

Dr. SHARFSTEIN. No. So our Federal grants I think in total, if I am correct, are about $180 million. Oh no, I am sorry. Let me get the exact number for you here.

Mr. WALBERG. Ms. Yang, you can get prepared for that same question.

Dr. SHARFSTEIN. Yes, it is about $180 million in grants. We haven't spent all that, though.

Mr. WALBERG. But that is what has been paid to you thus far.

Dr. SHARFSTEIN. Those are the Federal SSI grants that we have been awarded.

Mr. WALBERG. Who are the contractors and how much have they been paid?

Dr. SHARFSTEIN. There is a long list of contractors, so I could submit that for the record.

Mr. WALBERG. I would appreciate that. Were they bid competitively or sole-sourced?

Dr. SHARFSTEIN. For the major IT procurement we did a competitive procurement.

Mr. WALBERG. Any other contracts sole-sourced?

Dr. SHARFSTEIN. There were a couple much smaller contracts that were sole-sourced.

Mr. WALBERG. Appreciate that on the record as well. How would you rate the contractors' performance under contract?

Dr. SHARFSTEIN. Well, we let go our prime contractor; we did not think that they performed well. We were particularly disappointed with how some of the software worked. As I mentioned before, it was sold to us as out-of-the-box it would be able to do a lot of things that in fact it could not do out-of-the-box, and we wound up with some of the same problems that Minnesota had.

Mr. WALBERG. Mr. Chairman, if I could ask, for the record, if I could get also information to us that would clearly state whether you will seek further Federal funds to fix your mistakes.

With that, my time has expired.

Mr. JORDAN. I thank the gentleman.

Ranking member, the gentleman from Pennsylvania, Mr. Cartwright, is recognized.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

And thank you to all the witnesses who have joined us here today and thank you for your tireless efforts to get people signed up for affordable health care. Unfortunately, I come from a State that did not start its own exchange, Pennsylvania, which I think the failure to do that in Pennsylvania was an abdication of the responsibility of Governor Corbett on behalf of Pennsylvania's citizens.

In the last five yeas we have seen 12 hospitals in Pennsylvania close and I see the ACA and enrollment as a way to strengthen America's hospital system, and that includes Pennsylvania. Governor Corbett's decision back in 2012 to decline to establish an exchange was announced in a peculiar way: it was first celebrated in a press release by Americans for Prosperity, the Koch brothers'-funded enterprise. Twenty minutes later the Commonwealth of Pennsylvania itself made the same announcements in a press release.

The timing of that announcement, to me, certainly raised questions as to how the Koch brothers influenced that decision in the first place. Even more disappointing I want to say is Governor Corbett's decision not immediately to expand Medicaid for the more than 520,000 Pennsylvanians who could be covered. The Federal Government would have paid 100 percent of those costs for the first three years, phasing it down to 90 percent by 2020.

I have had a health care CEO in my district, in Northeastern Pennsylvania, confide to me that if Pennsylvania doesn't accept the Medicaid expansion, he is going to have to close one of his two hospitals. That is how important this is.

Instead of accepting Federal funding to expand a highly successful Medicaid program, Governor Corbett, in Pennsylvania, submitted a waiver proposal that would impose premiums, work search standards and limits to benefits for Medicaid recipients. According to the Kaiser Family Foundation, the governor's delay will cost Pennsylvanians hundreds of millions, if not billions, in Medicaid dollars this year and will leave hundreds of thousands of low-income residents without health care coverage in 2014 in Pennsylvania. It is unconscionable to me. It is time to quit playing politics, as Ranking Member Cummings has pointed out, with people's lives, with people's health. I urge Governor Corbett to reconsider his wrong-headed decisions.

With that, I would like to turn to the panel today. The citizens you represent, ladies and gentlemen, are fortunate that all of your States have made the decision to accept the Medicaid expansion.

Mr. Lee, I want to start with you. California has enrolled more than 1.5 million new applicants into Medicaid since October 1. Am I correct in that?

Mr. LEE. That is correct.

Mr. CARTWRIGHT. Could you tell the committee about what the Medicaid expansion means for those California residents and for the State as a whole?

Mr. LEE. Absolutely. I appreciate the question. We have been, in California, in very close partnership with our Medi-Cal agency; it is an arm-in-arm enrollment process. And people don't know what they are eligible for. We have had literally thousands of people break down in tears at the idea they have, for the first time in their lives, affordable coverage that is being provided to them. That is both for Medi-Cal coverage and for the subsidized coverage in Covered California. I have talked to many of them myself personally and our people on the front lines, whether they be insurance agents or customer service people, relay these stories constantly. It is touching many, many lives.

Mr. CARTWRIGHT. Thank you, Mr. Lee.

What about you, Mr. Leitz? Can you describe the impact of the Medicaid expansion on your residents and your State?

Mr. LEITZ. Congressman, we know in Minnesota that about 60 percent of our uninsured population is eligible for the Medicaid program, so as our numbers have grown through MNsure, we know that we are reaching the uninsured by enrolling them into Medicaid; and what that has enabled them to be allow them to do is to access services, oftentimes for the first time, to get preventive screenings, to care for issues that they might have had not cared for in the past. So it has been a very, very important thing both for them, as well as the caregivers that they seek.

Mr. CARTWRIGHT. Thank you, Mr. Leitz.

What about you, Dr. Sharfstein? Same question to you.

Dr. SHARFSTEIN. Sure. The Medicaid expansion is extremely important in Maryland. We have done an analysis that there are well over $150 million in uncompensated care reductions that we expect as a result of the expansion, and it matters a great deal. I am a pediatrician. I met one mom who was telling me this story about a very sick baby who needed a heart surgery that the Medicaid paid for, and then out came the daughter to give me a hug. They are real people in Maryland. My patients, when I see them in clinic, how the Medicaid expansion changes their lives.

Mr. CARTWRIGHT. I thank you, sir, and I yield back.

Mr. JORDAN. I thank the gentleman.

Ranking member of the subcommittee, the gentleman from Florida, Mr. DeSantis, is recognized.

Mr. DESANTIS. Vice chairman, not ranking member. I am on your team. That is all right.

Mr. JORDAN. You have been called worse, I am sure; you are in politics. But vice chair. Excuse me.

Mr. CONNOLLY. Not a bad thought, though, Mr. Chairman.

Mr. DESANTIS. Thanks to the chairman. I appreciate this hearing. I have to tell you, when I hear things like that this law is causing premiums to decline sharply for Americans, I don't know what to say after having dealt with so many disappointed constituents in my district. The question is who are you going to believe, those who are defending this law or your own lying eyes. And I think that the American people will make that determination.

Some of the things that are said are just factually not true. We keep hearing that this has led to expansion of coverage for 3 million young adults, but the people who have looked at that most recently have debunked that number and said it is probably less than 1 million. And oh, by the way, that is imposing a cost on families between $160 and $480 per policy. And, of course, some of the numbers back and forth are fine, but the central promise of this law was that if you liked your arrangements, this law would not negatively affect you and, indeed, it would benefit you with lower costs, and that central promise clearly has been broken.

If people like their plan, they may not be able to keep it. People are losing access to their preferred doctors. I don't have any constituent who has come to me and said their policies that they had have declined in premiums by $2,500, as was promised. Also, we don't talk about the increase in deductibles. People are paying higher premiums and seeing their deductibles go up, so they are spending way more out of pocket than they used to.

Can we put the slide up on the board?

[Slide.]

Mr. DESANTIS. So you have all of those things which we were told were not going to happen, but then we see a lot of people have seen their existing arrangements undermined or changed in a way that they would not have chosen to do it.

So what was the promise of this? It is constantly said everyone now has health insurance, but if you look, the CBO, when the law initially passed, they said it would be 37 percent of Americans right now who are uninsured would be covered, and then they said, well, actually, it is going to be closer to 40 percent of all the uninsured by this point in 2014. And the actual number is about 12.5 percent; and that is not just including these exchanges, that is including the Medicaid expansion and, of course, the age 26 rule.

So you have about 12.5 percent of the uninsured that have now been covered and, of course, at a great cost. We are seeing the cost here, just the amount of money that has gone into creating these exchanges. We are seeing the cost of people who have lost access to their doctors, people on Medicare Advantage. So it hasn't even produced what they said in terms of expanding coverage, and I think that that is something that has made a lot of folks very frustrated when they see numbers like that.

I just have a couple quick questions for California.

Mr. Lee, I read a news report where a couple in La Mesa had signed up for a plan in the Covered California, then they got a voter registration card sent to them that had the Democratic party already checked. Are you familiar with that report?

Mr. LEE. Yes, I am.

Mr. DESANTIS. And how does it become to where they would get something that would be pre-checked as the Democratic party? Is

that something that you have control over or is the elections office sending this stuff separately from Covered California?

Mr. LEE. Covered California has been designated a national voter registration agency, so it is a requirement under law that we send these out in California. Every voter registration form is provided to us by the Secretary of State's Office. This report is something we reported promptly to the Secretary of State's Office and is being investigated.

Mr. DESANTIS. Okay, thank you. I also read another report about Covered California, whether they are advertising to people who are in the Country unlawfully. Obviously, I don't think that they are lawfully allowed to get ObamaCare subsidies, but can you say how are you guys approaching that? Are you trying to get folks who don't have legal status to sign up on Covered California?

Mr. LEE. Absolutely not. And we are absolutely trying to communicate very clearly how a family that has mixed status—in California there are many families that might have one member of the family who is not a documented resident and another family member who is. We want to make sure those that are eligible for coverage get coverage, so we have been clearly communicating the rules on how a family should still come forward and we, quite honestly, great appreciated the guidance from the Federal Government to make it clear that immigration status information provided to Covered California is only used for that purpose to not discourage individuals as families coming forward to get coverage because they would be worried the information might be used by us for immigration purposes.

Mr. DESANTIS. But if someone cannot prove legal status, then that would mean they would not get any——

Mr. LEE. Absolutely not. Absolutely not.

Mr. DESANTIS. Okay.

Mr. Van Pelt, how many cancellations has Oregon had in the individual market, do you know offhand?

Mr. VAN PELT. I do not know offhand.

Mr. DESANTIS. The number I have is about 135,000 individuals who have lost policies because of the Affordable Health Care Act mandates. How many people have enrolled via the individual market in Oregon as of April 1st, do you have that number?

Mr. VAN PELT. In the qualified health plans, approximately 65,000, and then another 140,000 in Medicaid or Oregon health plan.

Mr. DESANTIS. And of the 140,000 in Medicaid, do you know offhand how many would have been eligible for Medicaid anyways?

Mr. VAN PELT. Approximately 100,000.

Mr. DESANTIS. Okay. So it seems to me that there were more policies canceled certainly than have signed up in the individual market. And then when you kind of control the Medicaid numbers, a lot of States have seen increases in States that didn't even expand Medicaid. So I think it is important that we are able to determine those.

I think I am out of time, so I will yield back.

Mr. JORDAN. I thank the gentleman.

The ranking member of the full committee, the gentleman from Maryland, Mr. Cummings, is recognized.

Mr. CUMMINGS. Mr. Chairman, I would rather one of my colleagues go ahead.

Mr. JORDAN. Okay. Then I believe the gentlelady from New Mexico is recognized.

Ms. LUJAN GRISHAM. Thank you very much, Mr. Chairman, and I also appreciate the panel today. I spent, actually, before coming to Congress, some time working with our State legislature and our current governor to enact legislation that got passed by our legislature. From the immediate we had to pass it three years three times in order for New Mexico to get started. So while you were pointing out the trials and tribulations, one thing that we haven't discussed today is that many States waited until the very last minute, and that, I think, also exacerbated some of the issues that you have identified today.

I am really interested in some of the education and outreach efforts and would love to try to have each of you talk to me a little bit about that going forward, targeting those folks that are still uninsured, really clarifying these numbers, looking at folks and businesses and those trends, working with all of your Navigators and Assistors and brokers. If each of you would talk to me a little bit about moving forward.

Mr. MATSUDA. Our outreach program in Hawaii is called the Heinola program, and we have arranged subgrants of our Federal funding to about 32 nonprofit organizations on all of the islands; and with those grants those organizations are hiring people to go out into the community to work with people from many different cultures and many different language groups to work with them face-to-face to help them understand health insurance, first of all, and then the Affordable Health Care Act. And if they are interested in looking into applying, then they will assist them with going through our application process for enrollment.

Dr. SHARFSTEIN. In Maryland we work with more than 2,000 insurance brokers. In addition, we have a Connector entity program where there are six regions each with a Connector. Each of those is working with local agencies. When I was way out in Western Maryland, I was meeting for another reason with a group called Allegheny Health Right, which it is the sole mission of that nonprofit to help people get health care for many years. They work with the medical community up there. And I was wondering and they said, actually, we are part of the coalition that got funded. So we have some great organizations across the State. It is one reason we have been able to hit our goals despite the IT problems.

Ms. LUJAN GRISHAM. I think that is really important. And as the rest of the panel answers, and I appreciate the reference to your partners who are part of those grant investments, but also looking at—tell me what you will do differently going forward, because while some of you met the targets, some other States are still really struggling. We could do a lot better in New Mexico. Although we did a good job, we could do a much better, for example, in the Medicaid outreach.

Ms. YANG. Congresswoman, I really appreciate this question because one of the things that I can say that based on Massachusetts' reform experience in the past eight years, outreach and education is really one of the most critical efforts; it is the most important

investment area, particularly the most vulnerable population, the low-income. They are the hardest to reach.

And if you look at the Massachusetts reform records, we have 97 percent of the residents insured. The 3 percent remaining are primarily low-income. And we are very proud to see the fact that we were able to bring 200,000 new people into subsidized coverage. That is a major step forward relative to where we were.

Mr. LEE. We have a lot of learning still to do, but I think one of the things, as we look forward, having insured probably close to 50 percent of those eligible for subsidies, it is going to be get harder and harder. The people that are not insured are folks that often have never had insurance. There is more education about what it means to be insured, and they don't believe that it could be affordable. That is a core education and outreach message, and we have done it with both advertising, but also with our on-the-ground people.

The other thing that I think has been critical for us and we are continuing developing is this is complex stuff, and having person-to-person support for enrollment in language; people who speak Spanish with Spanish speakers, speak Hmong——

Ms. LUJAN GRISHAM. And I want to actually, since I only have 45 seconds left, really have you hit that. We know that 8 out of 10 Hispanics are likely eligible for Medicaid, one of the Medicaid programs or subsidized coverage, and yet we have half the Hispanic population is not going to be insured; and I worry that we actually have too many steps in this face-to-face process to actually execute the deal.

Mr. LEE. Well, if I speak to that specifically, in our first three months in California, a very big State with a very big and important Latino community, 18 percent of our enrollment was Latino, which was way off our target. In the month of March it was 36 percent. We doubled the rate of insuring Latinos because it takes more touches; it takes education, it takes people on the ground doing enrollment. We are going to try to do better than that in our next round of open enrollment.

Ms. LUJAN GRISHAM. We have a couple seconds, and I think if the chairman will allow I think everyone can do a quick, concise answer. Thank you.

Mr. LEITZ. Congresswoman, very briefly. We have certainly seen the importance of working with agents and brokers on the ground; they are in every community, they know the communities very well. That has worked very well for us. The other area that we have been focusing very heavily on is with our Hmong and Somali communities, and also working with them like many of the other States on the panel, helping them understand the importance of insurance coverage, what the options are for them, and working with them in their languages.

Mr. VAN PELT. Thank you very much. Similar to other States, working very closely with community agents and community partners to help get the word out and, in fact, walk many of our citizens step-by-step through the application process.

Ms. LUJAN GRISHAM. I am way over, but thank you. I really appreciate all that and am very grateful for those responses. I would love for everyone to consider, and maybe at a future hearing, Mr.

Chairman, I know that the importance and value with complicated information on that person-to-person touch, but in my State I went to several different enrollments and they varied; but there were too many touches, and this notion of waiting for appointments and not having that work for the States who did the education and then a little more in-depth, and then go to an appointment with an Assistor and then have an Assistor or the Navigator help you actually then sign up, we lost, I would say, 50 percent of those folks in that line of touches, so I am thinking maybe too much. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. JORDAN. You bet. Thank you.

Dr. Sharfstein, I think earlier you said that you received approximately $180 million in Federal taxpayer grant dollars, the State of Maryland received that.

Dr. SHARFSTEIN. Through SSI grants, yes.

Mr. JORDAN. And you have spent approximately two-thirds of that, I think you referenced $120 million.

Dr. SHARFSTEIN. I think of that we probably have spent about $100 million.

Mr. JORDAN. Okay. And I think in earlier questions you indicated that you had to hire, because of Website concerns, approximately 200 more people to answer phones and work at your call centers?

Dr. SHARFSTEIN. That is correct.

Mr. JORDAN. Okay. I also think I remember that when Ms. Speier was asking I think each of you how you are doing, I think you said, doctor, that the State of Maryland is "meeting our goals." I think a lot of people would disagree with that.

Dr. SHARFSTEIN. Well, I was referring to the enrollment goal. I would absolutely agree we did not meet our goal in terms of the function of the Website.

Mr. JORDAN. Okay. But you met your enrollment goal as well?

Dr. SHARFSTEIN. That is correct.

Mr. JORDAN. My understanding is that CMS enrollment target number was 150,000 for the State of Maryland, and as of April 1st, as of a couple days ago, you have enrolled 60,000 people.

Dr. SHARFSTEIN. Our enrollment goal between Medicaid and the qualified health plans was 260,000, and we are about 295,000.

Mr. JORDAN. I am talking about the individual market enrollees.

Dr. SHARFSTEIN. So for our individual market we had an independent assessment of what the estimate would be and they estimated around 75,000. And what I testified is that we expect to get at least within——

Mr. JORDAN. Wait, wait, wait. I thought CMS told you your enrollment was 150,000.

Dr. SHARFSTEIN. No.

Mr. JORDAN. We have a document from CMS that says that, 150,000.

Dr. SHARFSTEIN. If that is the case, I haven't seen it.

Mr. JORDAN. So where is the 75,000 number coming from?

Dr. SHARFSTEIN. It comes from the Hilltop Institute at the University of Maryland at Baltimore County. We could provide the letter that explains that.

Mr. JORDAN. And that is your target goal, 75,000?

Dr. SHARFSTEIN. No. Our goal was for overall enrollment across Medicaid and qualified health plans, but insofar as how we are doing in terms of qualified health plan enrollment, the estimate——

Mr. JORDAN. Well, I guess here is what I am trying to figure out. You took $180 million of Federal taxpayer dollars. The Federal agency involved in implementing the Affordable Health Care Act is CMS. They said your enrollment target should be 150. And yet you can take the money but you can get someone independent to tell you what your goal really is, something smaller. When was that number, 75,000, given to you all?

Dr. SHARFSTEIN. That was the estimate that was given by the University of Maryland, Baltimore County.

Mr. JORDAN. When?

Dr. SHARFSTEIN. It was a revision of a report that they did in the last couple months.

Mr. JORDAN. A revision? What was the initial number, then?

Dr. SHARFSTEIN. The initial number they gave us was about 150,000.

Mr. JORDAN. Oh, imagine that, the number I just said. And when did you get the revision?

Dr. SHARFSTEIN. A couple months ago.

Mr. JORDAN. Oh, so you are into this and you are not coming close to the 150,000 and, shazam, you get a revision.

Dr. SHARFSTEIN. Well, they had made an error in the report and we can provide you their letter.

Mr. JORDAN. How convenient. The Federal Government gives you $180 million, they say 150,000 you need to meet. You see you are not going to meet that, you get someone to give you a revised number and suddenly, oh, now we are close. Defining the standard down is what it sounds like to me.

Dr. SHARFSTEIN. Well, you can judge for yourself. You can look at the letter that they gave, but I don't consider the Medicaid individuals to be invisible, Mr. Congressman.

Mr. JORDAN. I am not saying that either. All I am saying is the standard was here, then, suddenly, when you are not even coming close to the standard, the standard gets revised not by the Federal Government, who has given you the money, but by some independent agency that Maryland goes to and gets a number that they like. And I am not the only one who thinks you guys aren't doing the job. You have a Democrat congressman from your State. I have four letters from Congressman John Delaney from the State of Maryland, two of them were sent to you, where Mr. Delaney says this thing is such a mess, we encourage you to switch to the Federal exchange. Right?

So it is not Republicans saying this thing is a mess; it is your own congressman from your own State saying, look, I care about our constituents. With all the headlines, all the problems associated with the Federal exchange, you have a Democrat congressman from the State of Maryland saying you guys are such a mess, we should bag this and go to the Federal exchange.

Dr. SHARFSTEIN. Well, I testified that the IT didn't work. I mean, I don't disagree that we had a major IT problem. But it was overcoming that problem that allowed us to hit our enrollment goal.

Mr. JORDAN. No, you haven't hit your goal. We are talking about individual market enrollees. You have 60,000; you were supposed to be at 150,000. That is markedly short from your goal.

Dr. SHARFSTEIN. That was an estimate, never a goal, and it was an estimate that was in error. And you can judge from the University of Maryland——

Mr. JORDAN. It wasn't an estimate in error, it was the number you were given by the Federal Government, the same entity that gave you the $180 million of taxpayer money.

Here is what the President said. When did you let the Federal Government know you were going to come far short of this 150,000 number? Do you have to give the Federal Government periodic reports of where you are going to be?

Dr. SHARFSTEIN. Well, we have been working very closely with the Federal Government the whole time, so we have been providing weekly public updates on where our enrollment is since October 1st.

Mr. JORDAN. Let me ask you a couple more questions. I am over my time, and I will get to the chairman here.

How many people in your State lost insurance because of the Affordable Health Care Act, were kicked off their existing plans?

Dr. SHARFSTEIN. I think very few. There weren't that many cancellations, for example. There are some notices of non-renewal, and the carriers allowed people to renew for 12 months if they wanted to, our major carrier.

Mr. JORDAN. According to our reports, according to our reports, according to AP, what has been press accounts, 73,000 individuals in Maryland were going to lose their insurance because of the Affordable Health Care Act. And what you are telling me is your revised goal is approximately the same number, 75,000. So your revised goal of people you were going to sign up is we are going to sign up the people who were kicked off of the Affordable Health Care Act.

Dr. SHARFSTEIN. No. The problem with that is that there is also a market outside the exchange, and we are going to see the overall individual market inside and outside the exchange, including the people who also renewed their policy early, to be far more than we had in 2013. So you have probably as many people in the individual market outside the exchange as inside the exchange, plus you have people who renewed early and are still in those plans. So our carriers predict significantly more enrollment across the individual market.

Mr. JORDAN. You may predict all that. All I am saying is, according to press accounts, 73,000 Marylanders are going to be kicked off their plan because of the Affordable Health Care Act, and you are telling me your goal, the goal you were supposed to meet by April 1st, was only 75,000.

Dr. SHARFSTEIN. You are comparing apples and oranges, with all due respect.

Mr. JORDAN. I am comparing people who got kicked off because of this law and I am comparing the number you say you are going to sign up through your exchange, which is far below, roughly half, of what the initial number that CMS gave you.

Dr. SHARFSTEIN. I think an apples-to-apples comparison would be the size of the individual market before and after. So whether people have coverage in the individual market before January 1st versus after, because some people don't need subsidies, they will go right to a carrier.

Mr. JORDAN. Right.

Dr. SHARFSTEIN. So we are seeing not only just the exchange enrollment, the outside the exchange enrollment, which is probably going to be at least that, plus the fact that people could renew early. We are going to see a much bigger individual market. That is the apples-to-apples comparison.

Mr. JORDAN. But I think you are leaving out the fact, your calculations, what you just went through, those who were kicked off. There are certainly people who are now in the individual market; they just got kicked off their plan.

Dr. SHARFSTEIN. No, they were in the individual market before. It was an individual market plan.

Mr. JORDAN. I understand that.

Dr. SHARFSTEIN. So the apples-to-apples would be you were in the individual market before, you are in the individual market after. That is apples-to-apples. And we are going to see a huge increase in the individual markets after. That is more people covered.

Mr. JORDAN. Right, but I am looking at the number. The number you are saying is your goal, 75,000. You got lots of people kicked off; you got people who didn't have insurance before who you are supposed to try to sign up, even though you are woefully short in the chart Mr. DeSantis brought up; and we are back to the original point. CMS said here is $180 million, Maryland. Your goal is 150,000. That gets revised in the last few months, out of the blue, down to 75,000, and we have a congressman from your own State who is in the other party who says this thing is such a mess, you should have switched to the Federal exchange a long time ago. In fact, clear back in January he was calling for you to switch.

Dr. SHARFSTEIN. We investigated that possibility. There is no disagreement about whether or not our Website worked like we wanted it. It absolutely didn't.

Mr. JORDAN. One other thing. The President said, just days before, late September, he gave a speech in Maryland days before the launch, promising that ObamaCare would be "smoother in places like Maryland, where governors are working to implement it rather than fight it." And yet we know, you even indicated that it was a mess when it started. So what information were you communicating with the Federal Government that would give the President the assurance that he can make that kind of statement in your State, that this thing was going to work great, when in fact you said it didn't work well?

How could the President make that statement when we have seen what we have seen since October 1st in your State, where we have a Democrat member of Congress saying this thing is such a mess, go to the Federal Exchange? How could the President make that statement? What was he basing that on? Were you guys talking with the Administration? Were you telling them everything is going to be fine?

Dr. SHARFSTEIN. I think that it was well known that there were going to be glitches and bumps. We were communicating that publicly; the Federal Government was communicating that publicly.

Mr. JORDAN. Well, the President didn't get the memo. He didn't say there would be glitches, he said it would be smoother in places like Maryland, where governors are working to implement this rather than fight it.

Dr. SHARFSTEIN. Well, I think that we were certainly surprised by the scale of problems that we had after October 1st.

Mr. JORDAN. One last thing, if I could, real quick. I want to go to this slide. A whistleblower gave us this.

[Slide.]

Mr. JORDAN. High level business and technical architectural diagrams. This was a report. And we will give this to you. And this is difficult to read, I see, but we think this is important.

You have a copy there for him? Okay, good.

And what it says is all the red are problems associated with that, here we go, significant delay or risk, all the red; and there is a lot of red up there. Now, this was a report given to you all back in February 2013, and it shows you knew a year ago there were going to be some big problems. And you didn't communicate that with the Federal Government, who was giving you $180 million in taxpayer dollars?

Dr. SHARFSTEIN. The Federal Government received the reports from our internal IV&V team.

Mr. JORDAN. So the President had access to this report before he made that statement, just days before the launch of the Affordable Health Care Act?

Dr. SHARFSTEIN. We were communicating with CMS, the agency that we worked with. But I would say that subsequent to that period of time we were able to make progress that the team that was working on different parts of this——

Mr. JORDAN. Well, of course you were going to make progress. When it is this bad, you have no place to go but up.

Dr. SHARFSTEIN. In June of 2013, we passed an important test. I think this probably gave us a little bit more optimism that was deserved at the time. We were obviously very disappointed with how the IT went.

Mr. JORDAN. All right. I am way over, and I appreciate the chairman's indulgence.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. This is my time? This is my time, and I guess I would like to have my 12 minutes, just like Mr. Jordan.

Let me go to you, Dr. Sharfstein. I listened to Mr. Jordan and I wonder how many people he helped get enrolled under the Affordable Health Care Act. And I know it has been difficult. As you know, the last three Saturdays I spent all day helping people who were trying—as a matter of fact, I sponsored two events all day to get people enrolled under the Affordable Health Care Act. And I am glad we didn't take the attitude in Maryland that because the Website had a problem, that we would throw up our hands and say throw everything out.

I stood on Saturday and I talked to those people that waited all day trying to enroll, and I don't know what you say to somebody

when they come up to you and say this is the first time I have been able to get insurance in years because I had a brush with breast cancer. I don't know what my colleagues would say to that person. Say don't apply for the Affordable Health Care Act, when it is the law? I am not sure.

And we can nitpick and we can go ring around the rosy today, but I go back to what I said from the beginning. This is not just about a Website. And, as I understand it, the figures were adjusted in Maryland. I am going to refer to a February 23rd, 2014 article. Maybe you can help me with this. I am just going to read from it. It is the Baltimore Sun. It said the new number is 70,000 after it was corrected by the Hilltop Institute at the University of Maryland, Baltimore County, a nonpartisan health research organization that discovered its error weeks ago and sent a letter dated February 21st to Dr. Sharfstein, Health Secretary and Chairman of the Exchange Board. It was a footnote to one chart that wrongly also included open enrollment targets beginning next fall for 2015 coverage.

Does that refresh your recollection? Do you have that letter?

Dr. SHARFSTEIN. Yes, I have that letter here. The letter was written——

Mr. CUMMINGS. Now, did you go seeking that? I mean, Mr. Jordan has a way of asking questions that you never get a chance to answer. But did you go seeking that out? How did that work? What happened there? So we found we had a problem. People have problems every day. They don't just throw up their hands and just go and get all upset and say I can't do it. They find a way to get it done. And sometimes we make adjustments. We make adjustments every day of our lives. And I guess maybe the reason why I have that attitude is because, again, my mom and dad only had a second grade education; they were former sharecroppers. Worked like slaves, but yet and still they were able to have a son who became a congressman, so we believe in the can-do attitude. And I am hoping that we believe in the can-do attitude in Maryland.

Now, would you explain that to me, please?

Dr. SHARFSTEIN. Sure.

Mr. CUMMINGS. Since Mr. Jordan made such a big deal of this?

Dr. SHARFSTEIN. I think this is a letter from the Director of Economic Analysis at the Hilltop Institute, and he basically said that the report where they gave a figure of 147,000 represented the newly insured for both the first and second open enrollment periods. So a reasonable estimate of combined enrollment would be 160,000, including approximately 70,000 in the exchange and 90,000 in Medicaid.

Now, of note, at that time we had already set the goal of 260,000, and people came to us and said, well, now you are probably going to lower that goal. But we didn't. Even though we were way below 200,000 at that point, we did not lower that goal. And the governor still wanted us to shoot for 260,000. And I testified in the State legislature and I said even though the overall estimate has been lowered by the people that we hired to do an independent analysis because they made an error, we are not changing our goal, and in the end we wound up exceeding it by more than 10 percent.

Mr. CUMMINGS. Now, on Saturday, when I was at the Convention Center in Downtown Baltimore all day, trying to help people get insurance, I had an opportunity to speak to the Navigators. These are people who are not making a lot of money, but giving their blood, sweat, and tears because they wanted to touch somebody's future and change the trajectory of their destiny. And one of the things that was very interesting, we had so many people trying to get health care that, and correct me if I am wrong, that we had to basically put some people in a queue and say, look, we can't—there were so many we couldn't even get to them all and said we are going to get back to you during the week and bring you back in. Is that what is happening now?

Dr. SHARFSTEIN. That is exactly right. We expect the numbers for the first open enrollment to be higher than what we have now, even, and right now our whole call center is doing outbound calls to the people who weren't able to enroll by the end of March and had called and asked for extra help. It could be several thousand more or more than that, we will see. But I do think we may be able to surpass 300,000, against a goal of 260,000 in the face of incredible IT challenges.

Mr. CUMMINGS. The can-do attitude. Can-do. So let's talk a little bit more about the contractors. You know, when I served as the ranking member of the Maritime Subcommittee of the Transportation Committee, we had a situation where we had folks, contractors that were building boats for the Federal Government and the boats didn't float, literally. And sometimes I think some contractors have moved to a culture of mediocrity, and it is so very, very unfortunate because if we continue down that road we will be in a situation like I think about a trip that I made to Israel years ago, and it was a saying that they had everywhere, it said, If we are not better, we will not be. If we are not better, we will not be.

Can you kind of talk about the contractual situation here, what happened? You said that you had some bad situations that happened. And could we have foreseen some of that, Dr. Sharfstein?

Dr. SHARFSTEIN. Sure. So I think that the major, in retrospect, misjudgment, although it was hard to know at the time, the States faced the decision of whether to try to build a computer system from scratch with the requirements of the Affordable Health Care Act or rely on existing products, and we thought that it would be less risky to rely on existing products. We procured a system that had at its base an IBM Quorum software for eligibility and it was portrayed as out-of-the-box being able to work; we would just be able to configure it very easily. This has been a big point of discussion some of our State discussions. We have shared with the State legislature the parts of the bid that related to this and some other advertisements from IBM.

And, in fact, the software did not work as advertised, or even come close to it; it was defective and deficient on the launch and created a whole range of problems that we had not anticipated. And I think that the States that did more of the building themselves for this particular goal were more able to be successful, particularly the States that worked with Deloitte, California and New York, and we, in the end, because we can reuse a lot of the soft-

ware and hardware, are going to go with a particular solution that Deloitte built in Connecticut.

Mr. CUMMINGS. Now, does the State of Maryland plan on recouping some of the costs paid to Noridian for the development for the flawed product?

Dr. SHARFSTEIN. We do intend to seek recoupment of the funds, absolutely.

Mr. CUMMINGS. So now you are going with Deloitte, is that right?

Dr. SHARFSTEIN. Correct.

Mr. CUMMINGS. And what are Deloitte's plans for fixing or upgrading the Website?

Dr. SHARFSTEIN. The basic plan is to take the system that was developed in Connecticut, and has been very successful, and move it into Maryland with minimal changes; and basically plug it in. We have to build the interfaces to the Maryland systems and change certain elements of the Website and then use it in Maryland for the Fall open enrollment session.

Mr. CUMMINGS. So who is going to fund that and how will Maryland fund a new course of Deloitte's work?

Dr. SHARFSTEIN. So we will be putting our plan in a corrective action plan for the IT challenges that we face for the Federal Government and we will be seeking to have the same model of partnership funding that we have had so far.

Mr. CUMMINGS. I want to say to you, and I said it in your introduction, you know, I know what you have done for Maryland, I know what you have done for Baltimore, and I know the dedication of you and I am sure of all the other people sitting there. You know, Dr. Sharfstein, when we had Medicare Part D we had problems; and when you go back and you look at some of the comments that were made back then, we had folks who said, on both sides of the aisle, we have a problem, we have to work through it; we are going to get there. And we got there. Now you don't even hear about the glitches; it is like ancient history. And I can recall when Medicare Part D came through, and I think you were around then in Baltimore. If you recall, what we did is we held the same kind of events. Members of the Congress went from senior citizens' house, had all kinds of meetings, town halls. Most of us hadn't even voted for it, but it was the law and we wanted to make sure that it worked.

I hear all of this and I do wonder, I really wonder, and I know that there are problems with the Affordable Health Care Act, nobody has denied that, but I wonder what it would be like if we could just join in together to address those issues, because as my father used to say, when you are dead, you are dead; you are gone. So what we are talking about is trying to save people's lives. We are trying to make sure that we keep people healthy. We want to make sure that we give people a sense of a peace of mind. And I want that for my colleagues' constituents and I want it for mine, because I think that we have one life to live. This is no dress rehearsal, and this is that life. And I think we ought to be about the business of trying to help each other live the very best life that we can.

I will yield back on that.

Mr. LANKFORD. [Presiding] Mr. Bentivolio, would you yield to Mr. Jordan for a moment?

Mr. BENTIVOLIO. Yes.

Mr. JORDAN. I thank the gentleman for yielding.

My point was real simple. In essence what happened is the Federal Government enters into a contract with the State of Maryland. The initial terms of the contact were 150,000 enrollees in the individual market and $180 million going to the State of Maryland. Dr. Sharfstein just said they are going to go after some of the contractors they felt didn't fulfill their end of the deal; they are trying to recoup funds. The question is real simple: Is Maryland going to return some of the money? The initial contract was you get $180 million; you said you will sign up 150,000 people. And all of a sudden you get a new study that says, oh, we made a mistake, you only have to get 75,000. That was my point, plain and simple. So the question is real simple: Are you going to return some of the money?

Dr. SHARFSTEIN. Thank you, I will turn to that. I just want to say I am not—just having looked at this document, I am not exactly sure what this document is, so I am not sure exactly who this document was shared with. So if we can——

Mr. JORDAN. I am going with you. The number you gave is 147,000 people, right? The number——

Dr. SHARFSTEIN. No, I was just referring to the document that was handed to me. I just want to be clear, because I thought it may have been a different document.

To your point, we will follow all the applicable laws, and to the extent we are able to recoup funding, I certainly expect that it will be refunded to the Federal Government.

Mr. JORDAN. No, no, no. I am talking about the State of Maryland. Are you going to return Federal taxpayer dollars? The contractual agreement was CMS, here is the deal, 150,000 enrollees approximately; you get $180 million. You didn't meet that. You changed it. But when they issued the money, when it all set out, that was the goal. Are you going to return any money?

Dr. SHARFSTEIN. We are going to follow all the applicable laws in terms of funding.

Mr. JORDAN. But you are going to go after the contractors who you think didn't fulfill their end of their contract relative to the functionality of the Website.

Dr. SHARFSTEIN. That is correct.

Mr. JORDAN. Okay, so it is okay to go after them, but it is not okay for the Federal taxpayers to get back some of their money.

Dr. SHARFSTEIN. I think the Federal taxpayers should get back some of the money as we get money back from the contractors, yes.

Mr. JORDAN. I yield back.

Mr. CUMMINGS. Unanimous consent for one minute, Mr. Chairman.

Mr. LANKFORD. It is Mr. Bentivolio's time, but I would assume we wouldn't have any problem with that.

Mr. CUMMINGS. Just for one minute.

I noticed Mr. Lee was shaking your head. Why are you shaking your head, Mr. Lee? Did you have something you wanted to say?

Mr. LEE. Well, the HHS–CMS document that was an integral document prepared in September was prepared not as a matter of

contract between us and CMS, but they pulled from a range of things, and I will note the California estimate used in that document, because I saw it many months hence, took the end of two rounds of open enrollment and misconstrued and thought that was the goal for our first round of open enrollment. And our numbers for our independent in California, we had independent estimates developed. We have been public about them consistently. Those independent estimates in California, I noted earlier. Our open enrollment period high-end estimate was 800,000. At the end of two rounds of open enrollment it was 1.2 million. I think you are alluding to a September CMS internal memo that was never part of our contract, never part of our receipt. But they got the numbers wrong, with all due respect.

Mr. JORDAN. I wasn't alluding to anything in California; I was focused on Maryland, where the gentleman has had 147,000 and he said it was revised in February down to 73,000. That is all I was alluding to.

I would ask unanimous consent to have put in the record the letter from Congressman John Delaney to Dr. Sharfstein suggesting that they switch to the Federal.

Mr. LANKFORD. Without objection.

Mr. CUMMINGS. And I would ask unanimous consent that the Sun paper article dated February 23rd, 2014, and the Hilltop Institute letter to the Interim Executive Director of the Maryland Health Benefit Exchange dated February 21st, 2014 be entered into the record.

Mr. LANKFORD. Without objection.

Mr. Bentivolio.

Mr. BENTIVOLIO. Thank you very much, Mr. Chairman.

As a school teacher, I taught my students there were three branches of Government, the legislative, judicial, and executive branch. Kind of a checks and balances system, right? Except they should have taken my course they keep writing checks and my constituents are getting the balances.

I also taught my students bills were brought to the floor, went to committee, and then brought to the floor again for debate and passage, considering passage. But the ACA was passed before Congress could read and debate the bill. Shame on Congress for allowing this to happen. Shame on those who circumvented the congressional procedures long established that allows open and respectful debate before a vote and passage of a law.

The billions of dollars spent and the division it has caused in this Country is inexcusable, because Congress passed a bill before it was read and debated. This is shameful.

It seems here, listening to all these debates, the good, the bad, and the ugly, the money that was spent, and all we have is billions spent and division in this Country.

Let me just say this. In Congress we are the fiduciaries of the public interest, and I think few attorneys or citizens would sign a blank contract based on hopes and dreams. And today, after hearing your testimony and reading this testimony, all I see is more money wasted for failed systems, coverups. That is what I anticipate. Lawsuits will be filed, and every citizen knows somehow,

something at someone, it is going to be swept under the rug. More money spent.

It is unacceptable and we need to have accountability for the money already spent and the actions that are being taken as we move forward.

With that, I just have a few questions.

Mr. Lee, how many uninsured people are there in the State of California?

Mr. LEE. At this moment, I do not know that. I look forward to knowing that at the end of this year, when we do a State-wide survey, which we do every year in California to assess the status of people's insurance.

Mr. BENTIVOLIO. So do you know the population?

Mr. LEE. About 35 million.

Mr. BENTIVOLIO. Thirty-five million people. How many people in California have enrolled through the State exchange?

Mr. LEE. Approximately 1.2 million in Covered California's products and another approximately 2 million are currently enrolled in Medi-Cal.

Mr. BENTIVOLIO. Okay, so we have 35 million people in the State, 1.2 million. Wow, if it was a good product, you would think people would beat a path to your door.

Does the Website have the ability to show, of those who have enrolled in the State exchange, who has paid for their insurance premiums to date and those who have not paid their premiums yet?

Mr. LEE. No. After people enroll, they then, directly with the health plan they select, pay their premiums, and our plans in California report that approximately 85 percent of those individuals have paid their premium.

Mr. BENTIVOLIO. Eighty-five percent.

Mr. LEE. Yes.

Mr. BENTIVOLIO. Okay. Do you believe it is important to know how many people are actually going to receive insurance through your exchange?

Mr. LEE. Absolutely.

Mr. BENTIVOLIO. Okay, thank you very much.

With that, I yield back, Mr. Chairman.

Mr. LANKFORD. Thank you.

Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

I want to ask a question about the contractors. I don't think there has been, in all the hearings that have been had, enough of a focus on the contractors; Congress is so busy fighting off the Affordable Health Care Act itself. But I must say that the number of State exchanges that have problems, when you combine that with the problems we had in the Federal exchange really does show that technology is overrated. And I must say it also shows that since this has not been found just in the Federal exchange, this rollout problem, this problem with technology, just in this State or that State, but, rather, much to a wide cross-section of States, that we are dealing with a new problem, and that we ought to approach it that way.

Now, that means if it were new to the Government, State and Federal alike, it certainly looks like what we did not anticipate is

how new it would be to these contractors; and that was perhaps over-reliance or over-reliant faith put in the contractors. Now, I know that one of them, CGI, has its fingerprints on a number of the States, as well as the Federal exchange, and I can't believe that that is accidental.

Let me just ask you who use CGI, did you look to see what its record had been, for example, with Massachusetts? I see that Massachusetts no longer uses CGI. So those of you who used CGI, and there were several of you who did, would you speak up and indicate whether you checked to see what CGI's experience had been in doing precisely this kind of work, at least in Massachusetts?

Ms. YANG. Thank you, Congresswoman, for the question. First of all, let me say that ACA implementation has many components; IT implementation is one of them. We work with a wide range of different contractors, and some of them have been delivering excellent performance, ensuring our overall success.

Ms. NORTON. I am asking about CGI in particular.

Ms. YANG. Correct. Sorry about that. CGI was involved in Massachusetts' ACA implementation, specifically with the Website development, and we engaged them through a competitive procurement process consistent with guidance applicable to us. But, unfortunately, CGI's performance has been disappointing. They were behind schedule in delivering a required functionality——

Ms. NORTON. Did you use them from the beginning? Did you use CGI from the beginning?

Ms. YANG. I am sorry, I didn't catch that.

Ms. NORTON. Had you used CGI before?

Ms. YANG. No. The Health Connector was engaged in CGI for the first time with this contract.

Ms. NORTON. I see. When you rolled out your own product, did you use CGI?

Ms. YANG. No, we did not work with CGI. It was a very different, much simplified Website development. We worked with a local vendor.

Ms. NORTON. What led you to use CGI?

Ms. YANG. Why did we use CGI? We went through a competitive procurement process to——

Ms. NORTON. I don't want to know about your process. What about CGI led to its selection?

Ms. YANG. It was selected through a procurement.

Ms. NORTON. Everybody was selected through a procurement, Ms. Yang.

Ms. YANG. I am sorry, I was just trying to answer why we ended up with CGI.

Ms. NORTON. I only have so much time. Did they have experience? Did they have some other factor that made them stand out among those who competed for your contract?

Ms. YANG. It was the best vendor among the respondents.

Ms. NORTON. Best in what way, Ms. Yang?

Ms. YANG. In demonstrated experience?

Ms. NORTON. In this kind of work?

Ms. YANG. Yes.

Ms. NORTON. Mr. Matsuda, you used CGI. What made you use this company, which has had this bad experience across a number of States?

Mr. MATSUDA. I was not with the Hawaii Health Connector at the time the decision was made.

Ms. NORTON. Well, surely you know the answer.

Mr. MATSUDA. But my understanding is that we went through a full procurement, and a major factor in the decision was that CGI had been selected for the Federal exchange.

Ms. NORTON. Do any of you know whether CGI had experience doing this kind of work before? Who else used CGI, please, at the table? Anybody else at the table? Had CGI had experience comparable to this experience that you engaged them to do, to your knowledge, Ms. Yang and Mr. Matsuda?

Ms. YANG. Congresswoman, as you know, ACA implementation is a new project for all of us, so I wouldn't say CGI was engaged in identical projects. But in terms of comprehensive system integration, CGI does——

Ms. NORTON. All right.

Mr. Lee, did you consider CGI? You had a successful experience. Did they apply to California?

Mr. LEE. I actually don't think, as I recall, CGI bid, or it was not one of the finalists for us. So I don't know if they were a bidder, but the folks that did bid didn't have direct experience, because it was doing something new, and you needed to look at general track record, costs, the staff they provided, factors like that that went into our selection.

Ms. NORTON. You know, the District had a real heavy burden because Congress, in a spite amendment, made members of Congress and their staff go to the exchange and took them out of the Federal program. Well, it worked pretty well. I have to go back and make sure they didn't use CGI. I do think we have to look at these contractors and see what was the difference in the experience with contractors in particular. When you are doing something entirely new, which Congress has not taken in consideration in its criticism of this process, it does mean that you probably are asking contractors to do something that they haven't done either. The problem with this is we assume that contractors do something much bigger. You know, we talk about the big parts of the private sector, and we assume that these must be the same contractors who have handled things in the Country, so surely they could do the health care exchange for a particular State or, for that matter, for the United States.

Mr. Chairman, if I could say one thing, just to note for the record that Mr. DeSantis, from Florida, put up a graph which he said showed and questioned witnesses on the theory that it showed that these contractors and others, including the Federal exchange, had in fact performed below CGI expectations considerably. Please note for the record that his State, and now a great many other States, are directly responsible for that because they have failed to allow poor and middle class and disabled people to get health through expansion of the Medicaid exchange. That it happened, I have no doubt that the goals would have been met. So, especially coming from a State, to use such a graph without taking responsibility for

why there is a reduction in the uninsured Americans takes a lot of chutzpah.

Thank you, Mr. Chairman.

Mr. LANKFORD. I would only say one thing with that. In my State we also have that. Some of those individuals were covered by our Insure Oklahoma program prior to that, and they lost it. And part of the waiver issue was we had to remove that as a safety net.

Ms. NORTON. Mr. Chairman, that doesn't take care of those where you have an expanded Medicaid.

Mr. LANKFORD. That is what I meant. Those individuals that would have been——

Ms. NORTON. Did you have expanded Medicaid?

Mr. LANKFORD. We do not have expanded Medicaid, but we did have coverage there already with our Insure Oklahoma program.

Ms. NORTON. Well, Mr. Chairman, my remarks were limited to those who failed to expand Medicaid and had no other way, obviously, of insuring them.

Mr. LANKFORD. Right.

Mr. MCHENRY.

Mr. MCHENRY. Thank you, Mr. Chairman.

I would just ask this question of the whole panel. You all are in charge of your exchanges in your respective States. I will just go down the line. Yes or no, have you enrolled through these exchanges that you are in charge of? Mr. Matsuda?

Mr. MATSUDA. Excuse me? Yes.

Mr. MCHENRY. Okay.

Mr. Sharfstein?

Dr. SHARFSTEIN. No. You mean me personally, is that what you are saying?

Mr. MCHENRY. Yes.

Dr. SHARFSTEIN. No, I am a State employee.

Ms. YANG. No, I am a State employee.

Mr. LEE. I am sorry, I don't understand the question.

Mr. MCHENRY. Are you enrolled through the very exchange you are in charge of enrolling others.

Mr. LEE. Through State coverage.

Mr. LEITZ. Congressman, through State coverage I am.

Mr. MCHENRY. Okay.

Mr. VAN PELT. Thank you. Two things. First, I need to apologize and correct a statement I made earlier.

Mr. MCHENRY. No, you can use somebody else's time for that, sir.

Mr. LANKFORD. I can grant unanimous consent for additional time to be able to answer that, if he needs to, as well.

Mr. MCHENRY. Go right ahead.

Mr. VAN PELT. Thank you. Mr. DeSantis asked about the enrollment of our qualified health plans of April 1st. The correct number is 57,000.

With respect to your question, Congressman, I am not an employee of the State; I am self-employed and did not apply for insurance through Cover Oregon.

Mr. MCHENRY. Okay. Okay. So the question, and I ask this because this is one of the questions that my constituents ask about the laws that we live under and those implementing the laws, whether or not they are complying with them or living under them

are going through the same process. So I would ask you, there is a concern I have about personally identifiable information and folks that are putting information into the exchange and the safety of that information.

Would you personally guarantee that personally identifiable information is safe through your respective exchanges? Mr. Matsuda?

Mr. MATSUDA. What I do know since I have started in this position is that I verified that the exchange was given full authority to connect to the Federal hub after passing all necessary security——

Mr. MCHENRY. Yes, but we have concerns with the Federal hub as well. So you are sharing perhaps some concern?

Mr. MATSUDA. No, because——

Mr. MCHENRY. So let me ask you again. Would you personally guarantee that personally identifiable information is safe through your exchange?

Mr. MATSUDA. I believe it is secure, yes.

Dr. SHARFSTEIN. Recognizing that nothing is 100 percent safe, I believe the Maryland exchange has done what it needs to do——

Mr. MCHENRY. Is it about 80 percent safe, 90 percent safe, 95?

Dr. SHARFSTEIN. Well, if you look at what has happened in the private sector, there are a lot of things that can happen. But we have had no known incursions and, to your point, my personally identifiable information is in there. I did start an application; I put in my social security number. I had no qualms about doing that.

Mr. MCHENRY. Well, were you able to complete your application?

Dr. SHARFSTEIN. I didn't complete an application because I have coverage. I was just testing it.

Mr. MCHENRY. You were testing it. Okay.

Ms. YANG. Congressman, this is one of our highest priorities in terms of protecting people's private information. We have not had a data breach and I wouldn't be letting the exchange operate without having confidence that personal information was protected.

Mr. LEE. Similarly, the safety of personal information is our top priority. We are very confident that that information is being kept secure. We have had no data breaches and we have no incidences that we know of of individuals' financial or personal health information being breached in any way.

Mr. LEITZ. Similarly, Congressman, security is a top priority for us. We certainly do everything we possibly can to protect the information that goes in.

Mr. MCHENRY. Will you guarantee that?

Mr. LEITZ. Congressman, it is very much a top priority.

Mr. MCHENRY. I will take that as a modified, if possible, yes or no, however you want to see it.

Mr. VAN PELT. The Cover Oregon also meets the CMS security requirements, which have been validated by CMS. And we are not aware of any security breaches with respect to connecting to the hub.

Mr. MCHENRY. Okay. All right. I wanted to at least ask that. So in terms of lost applications and incorrect subsidies, it is not an error-proof system we have, obviously; there have been faults and failures, obviously.

But I have a story for you, Mr. Sharfstein. In your system in Maryland I have a staffer whose mother was given a notice by her insurer that, due to the Affordable Health Care Act, her insurance was discontinued, so she had to go to the exchange; and she began a three-month-long process to enroll in your exchange. I know that you have about 4,000 applications in your State that were given incorrect subsidies or lost applications. Is that about the right number?

Dr. SHARFSTEIN. We reported a subsidy problem about that number, right.

Mr. MCHENRY. Similar to that. Okay. So her experience is one that I know very well through her daughter and through her telling me the story. So the first roadblock for her in filling out the application was a question of her citizenship, which she could not verify. She calls the Help Line. The Help Line obviously is very helpful in all your States, as you all will attest to, when people have problems with the website; and they have been noted, I don't have to recount this.

But in her situation she was told through the hotline to fax her, I believe it was, driver's license and social security number to this open fax line. And she asked, well, do I put it to your attention, can I put it to someone's attention? No, just fax it to this number. Is that concerning to you, that you have somebody's driver's license and social security number given to this random fax number in order to proceed with the application?

Dr. SHARFSTEIN. It is not just like a fax in the corner that people wander by.

Mr. MCHENRY. I would hope not. I would hope not.

Dr. SHARFSTEIN. It isn't.

Mr. MCHENRY. Or a fax at a local truck stop or something.

Dr. SHARFSTEIN. No.

Mr. MCHENRY. I know it is a little better than that.

Dr. SHARFSTEIN. There is a Fulfillment Center and they have an approach to secure personal information, too. And we have to verify things like whether people are able to purchase coverage under the law.

Mr. MCHENRY. So those folks that are privy to that fax machine, or whatever the technology is that you use, privy to that? Are they vetted? Is there some safety and security that I can tell her that there was for her information?

Dr. SHARFSTEIN. Yes, you can. And particularly for the Fulfillment Center.

Mr. MCHENRY. Describe that for me.

Dr. SHARFSTEIN. Well, we work with Maximus, which is a company that secures a lot of personal information. They do, for example, they are an enrollment broker for the Medicaid program, they work in many States. They are a very big company that has extremely strong policies around protecting private information because they do it in a whole bunch of States. They are the ones who were staffing the Fulfillment Center that those faxes go to.

Mr. MCHENRY. Okay.

Mr. Chairman, the final question I have is you all have in your metrics the number of enrollees as a part of your measurement of the success of your respective exchanges. Do you have a cost per

enrollee? For instance, Maryland has spent about, what, $100 million, $150 million, in that range, to build the Website and the exchange? Is that about right?

Dr. SHARFSTEIN. Right. So far, about $129 million.

Mc. MCHENRY. $129 million. So about $2,000 per enrollee?

Dr. SHARFSTEIN. Well, again, we have enrolled 295,000 people, so it would be a lot less than that if you were to divide it. But if you look, from our perspective, we are looking over several years.

Mr. MCHENRY. Yes. So this is the individual market.

Dr. SHARFSTEIN. Right. But people on Medicaid are not invisible. This is how they get coverage in Maryland.

Mr. MCHENRY. But they previously had coverage.

Dr. SHARFSTEIN. They did not. A lot of them did not have coverage.

Mr. MCHENRY. A lot? How many?

Dr. SHARFSTEIN. The vast majority of them did not have coverage. These are people who have all gained coverage since January 1st.

Mr. MCHENRY. So if this is about the individual market getting individual folks in the market, the individual market getting access to insurance, is that not a fair measurement for this?

Dr. SHARFSTEIN. I don't think so. It is also how people on Medicaid get access to insurance.

Mr. MCHENRY. But they could have had access to insurance previously under Medicaid.

Dr. SHARFSTEIN. No they couldn't. They couldn't because——

Mr. MCHENRY. Not at all? I thought Medicaid was actually an insurance program.

Dr. SHARFSTEIN. The vast majority of people in Maryland, single adults, for example, did not have coverage. Now they have coverage up to——

Mr. MCHENRY. The vast majority of adults in Maryland did not have coverage?

Dr. SHARFSTEIN. Single adults did not have Medicaid coverage in Maryland.

Mr. MCHENRY. Okay.

Dr. SHARFSTEIN. Even if they were very poor.

Mr. MCHENRY. So how do you enroll in the individual market?

Mr. CONNOLLY. Mr. Chairman? Mr. Chairman, I don't object to my colleague having extra time; I just want to make sure equal time is granted to the Minority.

Mr. LANKFORD. Has Mr. Connolly seen me be unfair before?

Mr. CONNOLLY. No. I have no question about that. But I just wanted it for the record.

Mr. MCHENRY. If I can just ask one final question.

Mr. CONNOLLY. Certainly.

Mr. MCHENRY. And if the gentleman was here to see Mr. Cummings, I am being a little less greedy than he was with the time; and as members of Congrss we are but a little bit greedy with the time. Mr. Cummings is coming back in and I would revise that. Mr. Cummings was appropriately useful with his time.

Mr. CUMMINGS. Would the gentleman yield?

Mr. MCHENRY. I have no more time.

Mr. CUMMINGS. I used the exact amount of time that the gentleman——

Mr. MCHENRY. All right, how about this? I will yield back.

Mr. CUMMINGS. The exact amount of time.

Mr. MCHENRY. If you want to quibble with this. I certainly appreciate it.

Mr. CONNOLLY. Mr. McHenry?

Mr. MCHENRY. I reclaim my time.

Mr. Chairman, thanks so much for your generosity. I certainly appreciate the kindness of my colleagues and I will show you the same kindness.

Mr. CONNOLLY. And, Mr. McHenry, for the record, I was not objecting; I was simply trying to make sure that the Minority was granted equal time.

Mr. LANKFORD. I am going to do something out of order.

You have been seated for two and a half hours. Would you like a moment just to stand and stretch? This lady right here, Ms. Hanabusa, has also been seated two and a half hours waiting for questions. She is going to get the next questions. But would you like to stand for just a moment?

We will take just a very short recess just to be able to stand.

[Pause.]

Mr. LANKFORD. Ms. Hanabusa is recognized.

Ms. HANABUSA. Thank you, Mr. Chair. First, on behalf of the people of Hawaii, I want to thank you again. You were the manager of the measure that allowed us to name a post office after former Congressman Cecil Heftel. Thank you again for that.

And I would like to thank you plus the members of this committee for their unanimous consent to allowing me to participate.

Mr. Chair, one of the reasons why I asked to participate is because of the fact that the people of Hawaii were also very concerned about the reports of the money spent on our Connector.

Mr. Matsuda, I do want to say up front that I know you have inherited this. The Connector went into effect in 2011, July specifically, and you came on board in November. So to the extent that you can address some of these concerns, I would appreciate it.

First of all, one of the things that I think fundamentally we must all understand is Hawaii is truly different. I know everybody says that, but Hawaii is truly different. We are the only State that has the prepaid health care law that went into effect in 1974; and I think that is part of the issues that we have to understand as we look at these numbers. I saw the letter sent to the governor and it speaks to $205 million going to the Hawaii Connector, and I think they computed it out at about $44,000 per person. But let's begin there.

So, Mr. Matsuda, $205 million I think was the grant that you were entitled to. How much money did the State actually use?

Mr. MATSUDA. As of the end of this past calendar year, we have spent $57 million out of that amount.

Ms. HANABUSA. And it is my understanding that there was a request to extend so that you could spend the remaining amount or however amount you could justify, but the State has been denied that, is that correct?

Mr. MATSUDA. The operations and maintenance portion of the grant cannot be used beyond this calendar year, that is correct.

Ms. HANABUSA. So of the $205 million, so people understand us very clearly, how much money would either be returned to the Federal Government, if you want to answer it that way, or how much money do you get to continue to use?

Mr. MATSUDA. So in addition to the $57 million that has already been spent, we have obligated under contract an additional approximately $50 million So that means we have about $100 million, roughly, of the Federal grant money that has yet to be obligated or spent. The amount or the portion of that that is related to operations and maintenance, versus development money, which can be extended to next year, has yet to be determined. We are working with CMS to figure that out because we just got the decision recently. Obviously, we want to be careful about how we use taxpayer dollars, so the development money will be used just to the extent necessary to improve the system to fit our unique marketplace.

Ms. HANABUSA. And what you have testified before the State legislature is that—and I think I misheard you speak earlier—is that the Hawaii Connector cannot self-sustain in terms of if you base it purely on the amount of monies that are coming in in terms of premium percentage of 2 percent or so. Was that correct?

Mr. MATSUDA. Yes, that is what I testified to.

Ms. HANABUSA. And I think that was in line with the potential request to the Hawaii State legislature for State funds of approximately $15 million a year to continue the Connector. It may be less because of the number, but that was about the amount. Am I correct in that?

Mr. MATSUDA. Well, yes. Actually, we are going through a process right now to figure out how we can reduce those expenses substantially below $15 million.

Ms. HANABUSA. So the State is aware that it has to kick in, in essence, to cover the continuing cost of the Connector.

Mr. MATSUDA. Yes, but I think it is important to put it into context. The issue for us on the revenue side is that because of the Prepaid Health Care Act, virtually all small businesses in the State already have insurance for their employees, so there is very little incentive for them to leave a system that they have been accustomed to for almost 40 years. So I think it is incumbent on us, looking at that marketplace reality, to try to reduce the cost of the operations of our system as much as possible.

Ms. HANABUSA. So if we can just go through this very quickly. So there is said to be 100,000 total uninsured in Hawaii, of which about 58,000, almost 60,000 are really going to be covered by Medicaid expansion. So the only number that can be enrolled is about 33,000, is that about right? Because we have some that are ineligible because of immigration status.

Mr. MATSUDA. Yes. That is right if you are only looking at the uninsured. But there are other people who currently have insurance that might be able to find better quality or lower cost insurance through the exchange. So the potential on the individual marketplace is probably bigger than just the 33,000.

Ms. HANABUSA. If I may, Mr. Chair, if I can just have a little bit of leeway here, if you don't mind.

Mr. LANKFORD. I will give you some of Mr. Connolly's time.

Ms. HANABUSA. Thank you.

So, Mr. Matsuda, the thing that I really wanted to get to is, quite candidly, a level of frustration I have had with your predecessor and whoever was there. You know, I was not here when we voted the ACA; however, I do know that the ACA has an exemption for Hawaii, I think it is Section 1560, which is anticipated in the original law, because of our Prepaid Health Care Act. I have always asked, okay, what have you done or what does it mean, and we have not gotten a response on that. I do also know that there is a movement in Hawaii that we avail ourselves of Section 1332 of the ACA, which is really an exemption from the provisions; and it is supposed to be because you have a, I guess for lack of a better description it is called the Waiver for State Innovation. And, of course, we like to think that we were the major innovators in any kind of health care. But that doesn't kick in until 2017.

So the question is why hasn't the State or the Connector looked at this? Because the problem is the fact that prepaid health and the ACA are not meshing well. I mean, that is our problem. That is the reason why the Connector doesn't work; that is the reason why we can't go on the Federal system, because it doesn't take into account the uniqueness of Hawaii's law. Would you agree with me that that is your fundamental problem, that is the reason why it is not working?

Mr. MATSUDA. That is correct, Congresswoman, and we are very anxious to take advantage of the innovation waiver in 2017; and, in fact, we wish it would occur earlier.

Ms. HANABUSA. But what about the exemption in the law itself that exists today, which is Section 1560? Why haven't we availed ourselves of that? Or is there a way that you can go to the Secretary of Health and Human Services or CMS and say, we have got this waiver in the law and we have this waiver that we know you probably will qualify us for in 2017? Why haven't we done that?

Mr. MATSUDA. I am not an expert on that section of the law, but my understanding is that it only refers to preserving the exemption that we have for prepaid under ERISA. But the scope of the ACA is much bigger than that and includes other areas of the law. So I think there is a complicated legal evaluation that needs to be made to see if we can take advantage of it in the way that you are suggesting.

Ms. HANABUSA. And we haven't done that yet.

Mr. MATSUDA. I do know that it is under consideration by both the legislature and the State administration, and we are trying to assist with that.

Ms. HANABUSA. Thank you. Mr. Matsuda, like I said, this is something that you inherited, but, notwithstanding, you can imagine how people at home are very frustrated with this and, actually, they are very embarrassed that people are saying we have all this money and we have only enrolled less than 8,000 people. But the enrollment of the less than 8,000 is really a function of the existing laws that we have that are not meshing, and I would really appreciate it if you would keep us apprised of that, because that has always been a question that we have constantly asked, or I have constantly asked, is why have an exemption in a law, not use it, and

then have to wait until 2017, when we are clearly, I believe, the example that that provision, Section 1332, was intended to not have to address because we are exempted. But we are truly innovative, wouldn't you agree?

Mr. MATSUDA. Yes.

Ms. HANABUSA. Thank you very much.

And thank you, Mr. Chair, again. I yield back.

Mr. LANKFORD. Mr. Connolly.

Mr. CONNOLLY. Thank you, Mr. Chairman, and thank you for your courtesy to our colleague from Hawaii.

Welcome to this panel. It is a fascinating panel.

You know, I wish, on this subject, we could sort of move beyond the partisan talking points. If there are things to be fixed, why not come together and try to fix them? And if there are things to be celebrated, why not intellectually be honest and celebrate them?

But if you go into a subject matter unrelentingly for four years in opposition, then you are probably going to have the problem we had with today's hearing. In the Majority staff memo, the hearing purpose, and it says: The current enrollment numbers of ObamaCare are significantly lower than expected. Oops. Well, actually they are significantly higher than expected; they actually met the highest stretch number CBO set for them. They exceeded their own revised numbers after the Website rollout, and are at 7.1 million and counting. Anyone on the panel, can any of you think of a brand new program from scratch in less than six months that enrolled 7.1 million people? Anybody? No. Not even California.

Ms. Yang, Massachusetts. The individual mandate that we have in RomneyCare and ObamaCare, do you know where it came from intellectually? Do you know where its wellspring was? Liberal Democratic idea?

Ms. YANG. Sorry, Mr. Congressman.

Mr. CONNOLLY. It came out of the Heritage Foundation. It was a conservative Republican idea enshrined in both the Massachusetts because of a conservative Republican philosophy that felt, correctly, people needed to take ownership for their decision-making; and, therefore, they have to have some skin in the game, and thus the individual mandate. In fact, no less a figure than then Republican Speaker Newt Gingrich said that one of the reasons he opposed the Clinton health care initiative back in 1993 and 1994 was because it lacked an individual mandate. And yet, today, because of partisan politics, that individual mandate, conservative Republican intellectual wellspring, is now referred to as socialism.

Do you have an individual mandate requirement in Massachusetts that preceded ObamaCare, Ms. Yang?

Ms. YANG. Absolutely, Congressman.

Mr. CONNOLLY. And is it working?

Ms. YANG. It is working very well.

Mr. CONNOLLY. What happened to the population of uninsured in Massachusetts?

Ms. YANG. There is a very small percentage of our residents that were uninsured. Prior to the implementation of the ACA it about 3 percent. We are actually very optimistic that number has further shrunk because we brought more people into coverage, so we expect that number to be even less than 3 percent now.

Mr. CONNOLLY. Is that not the second lowest uninsured population in the United States?

Ms. YANG. I thought that was the first lowest.

Mr. CONNOLLY. Well, I think Hawaii has—what is Hawaii's, Mr. Matsuda?

Mr. MATSUDA. I am happy to concede to Massachusetts.

Mr. CONNOLLY. Oh, all right.

[Laughter.]

Mr. CONNOLLY. Then, Ms. Yang, you are even more successful than I thought.

Ms. YANG. Thank you, Congressman.

Mr. CONNOLLY. So in terms of Website, I heard the testimony here that Websites are not the same as the exchange, and Websites sometimes do have glitches, sometimes big ones, unfortunately. Did Massachusetts have glitches when it started, Ms. Yang?

Ms. YANG. Absolutely, Congressman. In fact, I would just say that the Website that we launched in 2007 looked nothing like the Website that we had prior to the ACA. Even the pre-ACA Website went through a journey both from a performance perspective and a functionality perspective. Technology is meant to evolve over time; it is meant to be innovative, improved as we gain experience, as we react to the market. So when we, unfortunately, experienced challenges with the Website, we were not panicking. We have gone through this before. These are things that we just need to work through. We have worked through it before. ACA is complicated, but it is not beyond technology. There are technological solutions: we need to identify the right vendor; we need to put the right team in place, and we can fix them.

Mr. CONNOLLY. Wouldn't it be fair to say the goal here for the ACA, the Affordable Health Care Act, known as ObamaCare, was never to have a perfect Website, it was to get people enrolled. Website is a method, not an end.

Ms. YANG. That is exactly right. And I would just say look no further than Massachusetts, because we did not have sort of the fortune of having a state-of-the-art modern Website. We had something very simple, but easy to navigate. We demonstrated the concept, but we didn't really have the benefit of the ACA Website, which really brings it to the next level. Now, it does bring a lot more convenience to people; it does improve people's experience. But at its fundamental, ACA is about coverage, and Massachusetts is demonstrating it.

Mr. CONNOLLY. Mr. Lee, one of the things asserted by some of my friends on the other side of the aisle who are never going to give this, ever, a positive mark of any kind, is that actually the number of people enrolled is masking the fact that it equals or is less than the number of people who have in fact lost their health care coverage. How many people are enrolled in California again?

Mr. LEE. Well, again, enrollment first through Covered California directly in our plans, about 1.2 million.

Mr. CONNOLLY. 1.2 million.

Mr. LEE. We have 1.9 million enrolled in Medi-Cal plans, and we don't know, and this is one of the things that is lost in this discussion, the number of people that enrolled directly with their health plans in Affordable Health Care Act-compliant plans with essential

benefits. We think that for the vast majority of the individual market that converted out of their plans this year didn't come to our marketplace because they weren't subsidy eligible, so they are now in the individual marketplace.

Mr. CONNOLLY. Right. But surely the enrollment in California is not exceeded by the number of people who have lost their private insurance plan.

Mr. LEE. Absolutely not. But, again, this term that is often used of people who have lost their coverage, people converted to different coverage. The vast majority kept coverage with their existing plan, or some came to the marketplace and benefitted from subsidies. So the term of lost coverage, people converted coverage and converted to new coverage that now meets essential benefits protections under the Affordable Health Care Act.

Mr. CONNOLLY. And is this a brand new phenomenon? Apparently, for the first time ever in history, people are losing their coverage and insurers are cancelling their coverage.

Mr. LEE. What is new is that no insurance company can turn people away that knock at their door. What is new is that people cannot be turned away because of a health condition. Health plans cancelled policies at their whim previously, and if people left jobs they were left potentially without insurance, etcetera. So we are in a new set of circumstances, but not the set of circumstances of people changing types of coverage or losing coverage.

Mr. CONNOLLY. Thank you.

Mr. Chairman, you have been generous and I yield back.

Mr. LANKFORD. Thank you.

Let me run through a few things here. The way your agency is set up for funding stream, once we get into next year or the next year, how is your agency funded, is it general revenue, is it percentages? Mr. Matsuda, you mentioned it was a percentage at some point. So I would like to just quickly know how is it funded in the days ahead. Mr. Matsuda?

Mr. MATSUDA. Currently, we are only funded by the Federal grant. We are a nonprofit corporation that is not part of the State administration, and we are before the State legislature right now with a funding proposal.

Mr. LANKFORD. Okay, so there is not a revenue stream at this point.

Mr. MATSUDA. I am sorry.

Mr. LANKFORD. I am talking about trying to keep your agency doors open next year.

Mr. MATSUDA. Excuse me. I forgot to mention we also have, by board of directors' policy decision, a 2 percent fee that is assessed against all plans that are sold in our marketplace.

Mr. LANKFORD. Okay, so that 2 percent fee is what covers that, plus whatever general revenue is allocated.

Mr. MATSUDA. Yes.

Mr. LANKFORD. Okay.

Dr. SHARFSTEIN. Ours is through a premium assessment across all State-regulated insurance.

Mr. LANKFORD. All insurance. And what is that percentage?

Dr. SHARFSTEIN. It is about $40 million a year. I don't know the exact——

Mr. LANKFORD. What is the percentage? That is a fee on all insurance.

Dr. SHARFSTEIN. Yes. Whatever it is, it works out to about $40 million. But I will——

Mr. LANKFORD. Three percent, 5 percent, .2 percent? Give me a ballpark. I won't hold you to it because it is ballpark.

Dr. SHARFSTEIN. It is probably in the 1 to 2 percent, roughly, but I will definitely have to follow up.

Mr. LANKFORD. But it is on all insurance.

Dr. SHARFSTEIN. All State-regulated, right.

Mr. LANKFORD. Okay.

Ms. Yang?

Ms. YANG. Mr. Chairman, as you know, the Massachusetts Connector has been in existence for the past eight years. We have historically been funded with a combination of State funding, the general fund, and insurance carrier administrative fee; and that is the reason is because, on the one hand, we serve as a distribution channel that really provides backroom function for the insurance companies at the same time we perform policy responsibilities and service for the State. We envision that model is going to continue post-ACA. We do not have expectation of additional Federal funding to support the administration. We have not yet made a decision at this point in terms of the fee percentage. Historically it is between 2.5 percent and 3.5 percent.

Mr. LANKFORD. Okay.

Mr. Lee?

Mr. LEE. Our ongoing revenue is going to be based on a carrier administrative fee. The current fee is on a per member, per month basis, 1395, which is a little bit over 4 percent of premium. And we are going to be reviewing and adjusting that on an annual basis based on what our revenue needs are as we adjust our expenses.

I would also——

Mr. LANKFORD. Could you help me real quick?

Mr. LEE. Yes.

Mr. LANKFORD. Per member, per month, is that the individual that holds the policy? Where is that?

Mr. LEE. That is built into the premium.

Mr. LANKFORD. 1395.

Mr. LEE. Yes. And I would note we did a lot of analysis of this, so this actually enables health plans to lower their costs, because our cost per acquisition of what it means to enroll an individual is far less expensive than it used to be in the individual market; and the individual plans have a reduction and no longer have an underwriting cost because there is no longer underwriting, guaranteed issue.

Mr. LANKFORD. It is amazing that people would beat a path to your door when they are going to be fined if they don't, so that does help for enrollment. And that is not being critical of you, but that is definitely a good promoter.

Mr. LEE. Well, actually, if I could, Congressman, when we talked to thousands of them surveying, for the vast majority the penalty is not a huge incentive. The incentive is finding health care that is affordable. And the size of the penalty compared to making

health care affordable is a much bigger factor. For some it is actually a factor, but for a small minority.

Mr. LANKFORD. There was a deadline that we faced, as well.

Mr. Leitz?

Mr. LEITZ. Chairman, we are funded through an assessment on policies sold through MNsure, and that is up to a 3.5 percent assessment.

Mr. LANKFORD. And that is per policy that is sold through the system itself?

Mr. LEITZ. Yes.

Mr. LANKFORD. Not all. Because Maryland it is everybody, right? Every insurance. You all's is just what is being sold through the system. Okay.

Mr. Van Pelt?

Mr. VAN PELT. Thank you, Mr. Chairman. Going forward, our financing is based on a 2.5 percent on premiums sold through the exchange.

Mr. LANKFORD. Okay. All right, a follow-up question on that. As you have the enrollment coming through, obviously the open enrollment just ended, another open enrollment opens up next year. You are looking at your budgets based on what has come in at this point and what you have. Is the agency sustainable? Is the target there to be able to make? And I will kind of go backwards through here. Mr. Van Pelt?

Mr. VAN PELT. Right now, the target is sustainable at the level that we have enrolled and the projections going forward. As many of our colleagues have spoken, you do have to manage the expense side to match the revenue side. We expect that, with the enrollment that we have, we can do that.

Mr. LANKFORD. Okay.

Mr. Leitz?

Mr. LEITZ. Mr. Chairman, yes, it is sustainable.

Mr. LEE. Very similar. It is absolutely sustainable and we will be balancing both our expenses and the revenue. But when we look at the 1.2 million people that are enrolled, we are very confident we can have a very going proposition in California.

Mr. LANKFORD. Okay.

Ms. Yang?

Ms. YANG. We also believe we are going to be sustainable. We have 30,000 qualified health member. We also have over 100,000 Commonwealth Care members currently served through the exchange. We also have 5,000 small businesses. And, lastly, we have 138,000 subsidized members in transitional coverage. We expect a meaningful percentage will be exchange members as well.

Mr. LANKFORD. Okay.

Dr. SHARFSTEIN. Yes, we believe it will be sustainable.

Mr. LANKFORD. Okay.

Mr. Matsuda?

Mr. MATSUDA. As indicated in my written testimony and in my discussion with Representative Hanabusa, right now sustainability for Hawaii is going to be a challenge, and we are trying to figure out how to reduce expenses and look for other ways to increase revenue.

Mr. LANKFORD. Okay. Have you talked to other States that are experiencing something similar? Most of the States, obviously, have found a way to be able to hit the balance on it. I would assume you are interacting with those, saying we are having this problem, who else is having it? Do you know of any other States that are having issues with that as they approach next year?

Mr. MATSUDA. No, I do not, but I imagine that any State that has a small population like we do and a small number of uninsured will be facing the same kind of challenge.

Mr. LANKFORD. Okay.

Mr. Van Pelt, I want to talk a little bit about the co-ops. That is a new invention as well. Obviously, that is in the middle of the market. Several of you have co-ops in the market. Oregon Health and Health Republic, both those names ring true there. Each received $60 million to be able to start up as a co-op. Are you familiar with how they are doing and how they are functioning within the exchange?

Mr. VAN PELT. No. I can get that information for you. It has been relatively low enrollment numbers, but I can get you greater detail.

Mr. LANKFORD. How is that interacting with the other companies and how is that working? Because the initiative was the initial perspective from the group that passed this, and I wasn't here when it passed, was to create some nonprofit that is sitting out there that would compete or that would go into markets that other places wouldn't go. Have you experienced that they are good competition for the others?

Mr. VAN PELT. I think it is always, we have had a very good turnout in terms of interest in both profit taxable not-for-profit and not-for-profit plans. So I can't say there has been much discussion or analysis of the impact of the co-ops.

Mr. LANKFORD. When you say there is not much discussion or analysis, can you tell us if it has made an impact? Is there any sense of sigh of relief of I am glad the co-ops are there, because we would not have met our goals without them?

Mr. VAN PELT. I don't believe so. I have not heard any of that conversation. Again, because the Oregon market has worked with both the interest of the, again, the profits, all kinds of health plans, I don't believe that it is felt that this has been a void that they specifically filled.

Mr. LANKFORD. Right.

Same for Massachusetts and Maryland. Maryland has Evergreen; Massachusetts has Minuteman. Is that correct, both of you?

Ms. YANG. That is correct.

Mr. LANKFORD. Has there been a sigh of relief to say I am really glad the co-op is there, because without them I don't know that we would have made it? Or have you experienced any issues or how is that working and functioning? Because, again, this is a new invention.

Ms. YANG. We are glad that Minuteman was interested in competing in the Massachusetts market. This is not the first time that we have had a new entrant into the market.

Mr. LANKFORD. Do you know how many enrollees they have at this point, how successful they have been in the market?

Ms. YANG. Several hundred. We can get back to you on that.

Mr. LANKFORD. Again, we have all the preliminary stuff. Their goal, I think, was 37,000 is what they had hoped to enroll.

Ms. YANG. I would defer to you on that.

Mr. LANKFORD. Okay. Just trying to figure out. Again, it was $156 million given to start this co-op up to hopefully go into an area that was under-served. I am trying to figure out in Massachusetts if it was meeting a need of under-served, and where that $156 million goes and how is the sustainability. They are going to have the same sustainability all of you have to deal with in balancing your budget; the co-ops do as well.

Ms. YANG. Absolutely, Mr. Chairman. We work very collaboratively with Minuteman, so to my best knowledge they continue to be very interested in competing in the Massachusetts market. I would just say that, as you know, Massachusetts is already very well served in terms of insurance companies. We have great coverage and we have many, many carriers competing.

Mr. LANKFORD. Right. That was my interest of why we spent $156 million to start a co-op to compete in an area that has quite a bit of competition already. I just didn't know how successful they were.

Ms. YANG. My understanding is that, and I agree with that, Minuteman comes in with a low cost model that could offer additional options for members to shop around. And we continue to believe that they are able to deliver that once we have the functionality.

Mr. LANKFORD. Okay.

Maryland, any issues on there? Anything we can fill in the gap on?

Dr. SHARFSTEIN. I would just say that it is probably too early to answer the question about the investment there.

Mr. LANKFORD. Sixty-five million dollars to help start up a co-op that would stand up, and there is quite a bit of competition in Maryland as well.

Dr. SHARFSTEIN. Maybe not as much as in Massachusetts. I would say that Evergreen is really focused on the control of cost through a very aggressive primary care approach, which we think is promising.

Mr. LANKFORD. Do you know how many they have signed up at this point?

Dr. SHARFSTEIN. In the individual market, they have signed up on the order of a few hundred. Their prices were higher than the market leader and I think that hurt them in the first year. But I think that they are signing up more in the small group market, where their prices are more competitive, and I think it is probably going to take a couple years to really understand their role and see whether they are able to succeed.

Mr. LANKFORD. When problems came up, and as you were approaching deadlines getting to October the 1st, was there a key person that you were supposed to communicate with or that would give you comeback to sign off, whether that be the Oregon site, which is great frustration on the Maryland site? Who was the point person that you were to report to and say, okay, we have some issues, we don't know where we are, we are still working through our testing for security; we are not launching well, we are going

to have to have a delay, whatever it may be. Who was the point person you were going back to for CMS to keep them informed?

Dr. SHARFSTEIN. I can say we had a specific person at Sacio who was the main point of contact.

Mr. LANKFORD. Okay. What is the name again?

Dr. SHARFSTEIN. I think her name is Amanda Cowley. She, I think, has left Sacio since the launch.

Mr. LANKFORD. Oh, so this was a separate contractor working for CMS?

Dr. SHARFSTEIN. Right, she worked for CMS. She was an employee.

Mr. LANKFORD. Okay.

Dr. SHARFSTEIN. She was sort of the liaison.

Mr. LANKFORD. So the name was Amanda?

Dr. SHARFSTEIN. Cowley. I just want to quadruple check the name.

Mr. LANKFORD. Great. So let's kind of run through.

Who was the point of contact for you? Somebody had to do sign-off to be able to answer questions for you. Yes, sir, Mr. Leitz.

Mr. LEITZ. Mr. Chair, similarly I believe our primary contact administrator at the time was Amanda Cowley at Sacio.

Mr. LANKFORD. Okay.

Mr. Van Pelt?

Mr. VAN PELT. Mr. Chair, I do not have that information with me today; I was not there, but I can get that for you.

Mr. LANKFORD. Thank you. We will just follow up.

Mr. Lee?

Mr. LEE. Amanda Cowley is the director of State exchanges and was the endpoint. We also had a State officer who had sort of day-to-day responsibility for sort of making sure all the elements were approved and checked.

Mr. LANKFORD. Okay.

Ms. Yang?

Ms. YANG. Same thing here; Amanda was the point of contact. We were in constant contact with the entire CMS team.

Mr. LANKFORD. Mr. Matsuda, you weren't there, I don't think, at that time, as well.

Mr. MATSUDA. Yes. I will have to provide that on the record later.

Mr. LANKFORD. That will be fine.

Ms. Yang, at some point I want to be able to follow up with you, as well. We have a document, and I will get you a copy of it, that says for policy development. This is a piece that walks through as far as how you were hitting the core as Massachusetts was walking through this. And I will read this to you. And, again, I want you to be able to get a copy of it and we can talk again later.

This was an August document talking through the Website and how things were working, and what they considered a go or a no-go status. Browsing was anonymously a go; creating an account was a go; submitting application was a go; eligibility determination, no-go; shop and compare, no-go; pay and enroll, no-go; lock user account, no-go; IT administration create account, no-go; broker quoting information, no-go; browse, compare, select plans, no-go. Of the 17 core functions, only 5 were assessed as a go in August at

that point, late August, as they were preparing for an October launch.

Was there a conversation at some point to say, okay, we have a lot of no-gos here; let's stall, let's delay? If so, who would that go to to be able to say, okay, we have a bunch of no-gos and we are getting really close to deadline and we may need some extra time?

Ms. YANG. So a couple of things, Mr. Chairman. I can explain this document. This appears to me was a steering committee minutes document, so it records the discussion that took place at the time. We did go through a comprehensive evaluation of the readiness of the system before we deployed the system on 10/1, and this was a record of the discussion that we had that looked at each component, which ultimately led to our decision to deploy what we did deploy and also what we did not deploy on October 1st.

Mr. LANKFORD. Who did you have to report to at CMS to say we are having problems in these areas, we are not going to be able to deploy? Was there someone you were held to account to to keep them informed?

Ms. YANG. Yes. As I mentioned, we were in constant communication with CMS; we still are. We have weekly discussions with them on all levels of details.

Mr. LANKFORD. The who is what I am looking for there.

Ms. YANG. Similar to the other States, Amanda Cowley was the director for, I think, State exchanges, and also her team that included our State officers.

Mr. LANKFORD. Okay.

This has been a very long day for you. I have a million more questions. We will follow up in the days ahead just to be able to go through the process.

I do appreciate you coming and for the conversation. You all are working very hard. No one is trying to push back and say you are not working hard or you are not trying to make something work. The frustration is obviously this is a round peg in a square hole at times, and trying to work through Federal regulations and what you already have in your State, trying to make that work, whether it be Hawaii or Massachusetts, and trying to function with that.

In my own State we had a plan called Insure Oklahoma that already existed that we assumed we were going to get a waiver for that we ended up not getting a waiver for, and having to have that flip; and suddenly a working State plan had to be punted to try to get into a website that then wasn't working. We had all the chaos of that as well.

So what you are doing and what you are trying to work through the process to be able to serve people is honorable, and I appreciate your service on that. The mess that surrounds all this in the law, and trying to execute a law that has many, many complicating and conflicting parts of it is a major issue, and I think will continue to be a major issue.

So, with that, we are grateful for your time to be here. Thank you, and we are adjourned.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Joshua M. Sharfstein, M.D.

Secretary of Health & Mental Hygiene

Office of the Secretary

201 West Preston St.

Baltimore, MD 21201-2399

Dear Secretary Sharfstein:

Perhaps too forward, but I write today to formally request a specific assessment of the idea I first raised almost a month ago of switching in whole, in part, or on a temporary basis to the federal health exchange while the Maryland Health Connection website is being repaired. I write this as an open letter so that you can respond openly as well, because transparency benefits everyone.

The White House recently released data that indicates that 2.1 million Americans have signed up for private insurance nationally, including over 1 million via the federal marketplace at Healthcare.gov. Nationwide, this means that we have achieved 30% of the original goal of enrolling 7 million Americans this year. However, only 18,257 Marylanders have been able to enroll thus far, which is only 12% of our state's goal of 150,000. We have fallen quite far behind the national average and we're running out of time.

As we both know, there are real people behind these numbers. Our "enrollment gap" means that roughly 26,000 Marylanders, including approximately 4,000 that I represent in the Sixth District, are still lacking coverage because of Maryland's troubled health exchange (these numbers are estimates based on the difference between performance at 30% vs. 12%). Frustrated and concerned Marylanders from Montgomery to Garrett County have contacted my office on this issue since October. I continue to press this question out of concern for my constituents.

Since I raised the idea of switching to the federal exchange on a temporary basis, your office has responded to say that you are evaluating that option. I understand that my idea of transitioning to the federal website may contain challenges that I am underestimating and it may not, in fact, be feasible. For this reason, I am asking for a specific analysis from you as to the "pros and cons" of switching to the federal exchange for all or part of the Maryland interface. This analysis can be very brief, but should cover a high level overview of the technological feasibility, cost and timing considerations and should be described in comparison to the same considerations with respect to the base case of repairing the Maryland Health Connection.

You and I share a commitment to the success of the Affordable Care Act (ACA). The ACA can accomplish two very important things: ensuring all Americans have access to health care and bending the cost curve on health care

expenditures. For the ACA to accomplish these objectives, however, it must be implemented correctly. Effective implementation includes a large number of Americans successfully enrolling in private health care coverage.

More is at stake than just this mission; ACA implementation goes to the heart of government's ability to execute. At the center of a progressive agenda is the notion that government can and should engage in transformative policies to help the American people. At the center of that center must be the belief that government can successfully manage these initiatives. Otherwise, no one will trust government to attempt to make a difference in people's lives. At some point, we must collectively and critically evaluate the process associated with building the Maryland Health Connection and the original federal site, but our first priority must be ensuring access to health care for all Marylanders.

I agree with Maryland's decision to build its own website and I remain open to the view that having our own website is still our best option. I suggested a switch to the federal site - as perhaps even a temporary matter until our site is ready - so that peak volume of enrollees could be handled in advance of looming deadlines. I was hoping the suggestion might have avoided the numbers we saw for the January 1st deadline.

With less than three months remaining in the open enrollment period, each day is critical. Given how fundamental health care is to the lives of my constituents, I feel that further discussion of the options available to the State is essential. It is important to understand if we have viable alternatives or if the best course of action remains a reboot of the existing product.

I thank you and the Governor for your efforts to make this work, truly. The legislative fixes being proposed by the Governor are very constructive and the personal attention both you and he are giving this issue will lead us in the right direction. Your collective commitment to the well-being of all Marylanders can never be questioned.

I look forward to your response.

With my deepest respect and appreciation,

John K. Delaney

Ted Deutch: Health care made affordable

February 23, 2014|By Ted Deutch

Joshua Benson developed a rare disease, lost his pancreas due to surgery, and was diagnosed as a Type One Diabetic all before his 25th birthday. Despite needing costly insulin injections, enzyme treatments and frequent doctor visits, he never worried about the cost of his care.

That changed when he aged out of his parents' health insurance policy and had to start paying for his care out of pocket. His insulin expenses alone surged to $800 a month. He worried constantly about what would happen if he needed more serious treatment. For Josh, like most uninsured Americans, the cost of major surgery could mean bankruptcy.

Before the Affordable Care Act, Josh would have gone uninsured for years. The health insurance industry's business model depended on denying coverage to people with pre-existing conditions and dropping healthy customers when they got sick. That all changed last fall when health care reform finally took effect.

Last November, Josh attended an event at a Delray Beach public library and enrolled in a platinum health plan on the new Marketplace. A $215 tax subsidy lowered his premiums to just $133 a month. Like all plans on the Marketplace, Josh's coverage includes the essentials like prescriptions, preventative care, mental health services, visits with specialists, and more.

Every day, more Americans are enrolling in the new Marketplace. Though the initial launch of HealthCare.Gov was disappointing, the website is now running smoothly. Today, 3.5 million uninsured Floridians may finally have a way to find affordable health coverage. They are workers whose employers do not provide benefits and self-employed entrepreneurs who cannot swing the premiums. They are single mothers who fear one illness could bankrupt their families and grandparents who are not yet eligible for Medicare. They are young people, like Joshua, whose pre-existing conditions have locked them out of America's health care system.

The time for scare tactics and politial attacks is over. Josh's story reminds us that the Affordable Care is not about politics, but about making coverage affordable for working families.

Floridians have until March 31 to enroll in a plan on the new Marketplace online, by phone, or with a trained counselor. Costs will vary according to family size and income, but there is plenty of time to explore your options. Learn how to begin at http://www.GetCoveredAmerica.org.

Ted Deutch is a Democrat representing Florida's 19th congressional district.

Available at: http://articles.sun-sentinel.com/2014-02-23/news/fl-healthcare-deutch-viewpoint-20140223_1_health-care-reform-pre-existing-conditions-affordable-health-coverage

The Hilltop Institute

analysis to advance the health of vulnerable populations

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February 21, 2014

Ms. Carolyn Quattrocki,
Interim Executive Director
Maryland Health Benefit Exchange
750 East Pratt Street, 16th Floor
Baltimore, MD 21202

Dear Ms. Quattrocki:

I am writing regarding the enrollment projections for the Maryland Health Benefit Exchange and the Medicaid expansion as presented in the Maryland Health Care Reform Simulation Model which was produced by The Hilltop Institute in July 2012 on behalf of the Maryland Health Benefit Exchange. We have identified some mis-labeling of tables and an erroneous footnote in the Model description. The purpose of this letter is to correct these issues and clarify the estimates presented in the Model.

The report as published in July 2012 estimated a total newly insured enrollment of approximately 249,000 in fiscal year 2014, including (a) 147,233 through the first open enrollment through March 31; and (b) 101,685 in Medicaid through June 30. Specifically, footnote 1 of Enrollment Projections table stated, "Health Care Reform programs start on January 2014. Medicaid enrollment data for FY 2014 correspond to 6 months of enrollments. However, Exchange enrollment reflect 'Open Enrollment' period, which is from October 2013 through March 2014."

However, this footnote was in error. The 147,233 figure actually represented the newly insured in Maryland for both the first and second Exchange open enrollment periods in 2014, and the 101,685 figure reflected the model's estimate for Medicaid enrollment through the end of calendar year 2014.

Given these estimates for calendar year 2014, a reasonable estimate of combined enrollment for Exchange and Medicaid in fiscal year 2014 would be approximately 160,000 newly covered individuals, including (a) approximately 70,000 in the Exchange through March 31, 2014 and (b) approximately 90,000 in Medicaid through June 30, 2014.

It is important to note that the simulation model projections and the estimates cited above do not include individuals who were insured immediately prior to their 2014 coverage. Some private insurers have estimated that 30,000 to 50,000 insured people who purchase coverage in the Individual Market would qualify for Federal subsidies through the Exchange. However, an unknown percentage of these individuals will actually obtain coverage through the Exchange. A broad range of estimates for the number of individuals who were previously insured prior to initiating new coverage in the Exchange might be 5,000 to 30,000. This brings the total estimate for enrollment in fiscal year 2014 to a range between 165,000 to 190,000.

Finally, The Hilltop Institute is planning to revise the current Model estimates based on more recent data and analysis of the Census Bureau's Current Population Survey. The revision will be completed in six to eight weeks.

Please contact me if I can be of further assistance in clarifying the Simulation Model estimates and assumptions.

Sincerely,

S. Hamid Fakhraei

S. Hamid Fakhraei
Director of Economic Analysis

cc: Joshua M. Sharfstein, M.D.
Cynthia H. Woodcock

JOHN A. KITZHABER, MD
GOVERNOR

May 15, 2014

The Honorable Darrell Issa
Chairman
Committee on Oversight and Government Reform
2157 Rayburn HOB
Washington, DC 20515-6143

The Honorable Jim Jordan
Chairman
Subcommittee on Economic Growth,
Job Creation, and Regulatory Affairs
2157 Rayburn HOB
Washington, DC 20515-6143

The Honorable James Lankford
Chairman
Subcommittee on Energy Policy, Health Care
and Entitlements
2157 Rayburn HOB
Washington, DC 20515-6143

Attn: Brian Blase and Sarah Vance

Dear Chairmen Issa, Jordan, and Lankford:

On behalf of the State of Oregon and Cover Oregon, I am submitting responses to the supplemental questions from Chairmen Jordan and Lankford dated April 21, 2014. Thank you for the extension until May 15, 2014 to submit our responses. These answers were prepared to the best of our knowledge in a good faith effort to respond to all of your questions, but we nevertheless reserve the right to supplement this response with any information that should become available subsequent to this submission.

1. To date, how much money has the state received in establishment grants to set up a health insurance exchange?

In total, Oregon has received $305.1 million to develop the health insurance exchange. Cover Oregon has received three establishment grants for a total of $244.2 million. Oregon Health Authority (OHA) has received three establishment grants for a total of $60.9 million.

   a. Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?

Cover Oregon has not received any additional federal funds outside of the federal exchange establishment grants. The Oregon Department of Human Services (DHS) Modernization and the Health Insurance Exchange projects relied upon a shared architecture and technology platform.

Outside of the federal exchange establishment grants, a total of approximately $58.7 million in federal funds were provided by Medicaid, CHIP, and SNAP for the exchange and related systems.

b. How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?

As of April 2014, Cover Oregon has spent a total of $195 million, of which $122.9 million (63%) was related to IT systems, plus $11.6 million for hardware. OHA has spent $119.7 million in federal funds for the development of the state's exchange and related IT systems. This includes the amount that OHA received in exchange grants plus the 11-13 federal funds received outside of the exchange grants.

c. How much has the exchange obligated to spend, but has not yet been spent on exchange development?

Under the leadership of new executives, Alex Pettit as Acting Chief Information Officer and Clyde Hamstreet as Interim Executive Director, Cover Oregon has reduced its technology and other contracts to the minimum necessary to meet is its obligations to its 2014 enrollees, its insurance agents, and its insurance carriers, and to transition to the federal technology for 2015 enrollment.

It is estimated that the remaining obligations to support the system through December 2014 is $28 million. Each of Cover Oregon's professional service contracts has a 30-day termination notice provision. If the contracts were canceled immediately, the cost of termination is estimated to be $22 million; however, the actual cost with potential claims and counter claims cannot be realistically known without significant legal and business investigation. Additionally, Oracle is asserting that there is approximately $25.6 million of unbilled services that have been previously delivered, but not yet paid by Cover Oregon.

d. Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?

No formal request has been made.

2. Please provide the list of all contracts awarded to develop the exchange and its related systems, including the following information for each contract:

Please see **Attachments 1 and 2** for spreadsheets listing Cover Oregon and Oregon Health Authority contracts for answers to Questions 2a-f.

a. When was the contract awarded?

b. What was the ceiling value of the contract and how much did the vendors receive to date?

c. Was the contract competitively bid or sole sourced?

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

e. Who is the responsible official for overseeing the contract?

f. How many contract modifications were made from the start of the contract?

Under the contract terms and conditions, who is financially responsible for fixing problems with the system?

The standard terms and conditions in Cover Oregon contracts provide that each contractor is financially responsible for any failure to deliver or perform the contracted services. The specific language includes:

> If Contractor commits any material breach or default of any covenant, warranty, obligation or agreement under this Contract, which may include failure to perform the Work under this Contract within the time specified herein or any extension thereof, or failure to pursue the Work as to endanger Contractor's performance under this Contract in accordance with its terms, and if such breach, default or failure is not cured within 14 calendar days after receipt of Cover Oregon's written notice, the Contractor shall be in breach of the contract. Remedies for contract breach include: withholding all monies due for Work and Deliverables that Contractor has failed to deliver within any firm performance dates agreed to by the parties in writing or has not performed in accordance with the terms of approval outlined in this Contract in all material respects; or initiation of an action or proceeding for damages, specific performance, or declaratory or injunctive relief; or setoff against payments due Contractor under this contract.

With respect to the contracts with the State's primary development contractor Oracle, see the warranty and repair provisions in the Dell Price Agreement §§ 3.8, 3.8.3, Amendment #1 to the Dell Price Agreement, the Mythics License and Services Agreement §E, the Oracle License and Services Agreements §E, and the On Demand Ordering Document No. US-14786492-OD-04-MAR-2013 §§9-10. Please see **Attachment 3** for relevant excerpts of the warranty and repair provisions. Full copies of the contract documents are available upon request.

3. Does the exchange plan to continue with the current contractors or terminate and replace with more capable vendors? If the exchange decides to award new contracts, will all new contracts be awarded through competitive bids?

Cover Oregon is reviewing all IT contracts to determine what contracts are needed to transition to the federal exchange technology. Cover Oregon is planning to end its contract with Oracle as of May 28, 2014, though Cover Oregon has requested to extend Oracle's contract into June 2014 to ensure a smooth transition of the current system to OHA.

On May 8, 2014 a 45-day contract with Deloitte was executed to conduct a Gap Assessment/Requirements Analysis for transitioning the private insurance enrollments to the federal technology and leveraging current technology for Medicaid eligibility and enrollment.

Moving forward, Cover Oregon will award deliverable-based IT contracts on a project-by-project basis. Generally, for contracts with an award amount of more than $100,000 that are federally funded and do not fall into a sole source exemption, contract awards should be conducted through a competitive bid process.

4. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?

Please see **Attachments 1 and 2** for answer to Question 4.

5. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

At this time the State does not plan on requesting additional federal grant dollars for development of the exchange. The Cover Oregon Board of Directors has decided to stop further development on the current state website for private health insurance. Instead, beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology to enroll people in private plans. The estimated cost to fix the current system would have been $78 million. It is estimated it will cost $4-6 million to transfer to the federal technology starting in mid-November. As of April 30, 2014, Cover Oregon has spent $122.9 million to develop the IT system, and the original estimate was $84.4 million through April 30, 2014. Cover Oregon continues to pay its main development vendor to stabilize and operate the system to allow for a smooth transition to the federal exchange.

6. To date, how much has the state or the exchange spent on advertisements publicizing the law and/or the exchange? Did the state or the exchange use federal or state funds?

As of April 2014, Cover Oregon has spent approximately $13.7 million to an advertising agency vendor, all of which came from federal grant funds. The work conducted by this vendor included advertising, outreach, and public relations support.

7. After September 31, 2013, approximately how much has been paid in bonuses to exchange employees?

After September 30, 2013, Cover Oregon has paid no bonuses to any employees. There were a number of employees that were required to work on holidays that were paid additional pay pursuant to general standard practice.

8. What are the estimated operational costs for the exchange in the years 2014, 2015, and 2016?

In February 2014, Cover Oregon presented budget information to its Board which reflected the following estimates:

- 2014 remaining grant budget: $90,505,385
- 2015 budget: $50,017,502 (estimated)

- 2016 budget: $50,947,220 (estimated)

On April 25, 2014 the Cover Oregon Board of Directors decided to use the federal exchange technology for private insurance enrollments, which will change financial projections for 2015 and beyond.

a. What revenue sources will the state utilize to finance the exchange in these years? What is the expected revenue?

Previously, Cover Oregon was planning for self-sufficiency beginning in 2015. Oregon Senate Bill 99 (2011) identifies how Cover Oregon would be funded in 2015 and subsequent years. Please see **Attachment 4** for a copy of SB 99.

Information presented to Cover Oregon's Board in February 2014 reflected federal grant sources to fund 2014 operations for a total of $90.5 million (the remaining grant budget). In 2014, Cover Oregon plans to charge an assessment on participating carriers (for qualified health and dental plans) and an assessment on state programs (for Medicaid redeterminations) to establish a reserve for 2015 self-sufficiency. Accumulated carrier assessments in 2014 were estimated at $8.5 million and $15.3 million for state programs; however, Cover Oregon recognizes such revenue estimated may vary from actual assessments—based upon actual enrollments and Medicaid determinations.

On April 25, 2014 the Cover Oregon Board of Directors decided to use the federal exchange technology for private insurance enrollments, which will change financial projections for 2015 and beyond. Cover Oregon is in discussions with CMS to determine funding arrangements. A new business plan is in development in consultation with CMS but it will not be ready by the due date for this request.

b. How will the state address any deficits in the exchange's budget?

Previously, the purpose of the reserve funds was to offset any budget deficits that may occur in 2015 and beyond. On April 25, 2014 the Cover Oregon Board of Directors decided to use the federal exchange technology for private insurance enrollments, which will change financial projections for 2015 and subsequent years.

c. Will the state seek any federal money to help finance the exchange's operations?

On April 25, 2014 the Cover Oregon Board of Directors decided to use the federal exchange technology for private insurance enrollments, which will change financial projections for 2015 and subsequent years.

9. Who was the state's primary point of contact at CMS?

With respect to Cover Oregon, Amanda Cowley, Director of the State Exchanges Group at CCIIO, was the primary contact until she resigned in December of 2013, followed by Terence Kane, State Officer at CCIIO until May 2014. Myisha Gatson is Cover Oregon's current primary point of contact at CCIIO.

With respect to OHA, Terence Kane (and predecessor Leslie Shah), State Officer at CCIIO, is currently OHA's primary point of contract. Yolande Calhoun is the technical state officer assigned to Oregon to partner with Mr. Kane as primary contact. OHA has also had contact with Amanda Cowley and Patricia Boozang, a contractor for CMS who helped facilitate the various communications. The CMS Medicaid primary point of contact is David Koppel.

a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? What was the role?

With respect to Cover Oregon, on multiple occasions, CMS conducted on-site visits to Cover Oregon, and numerous conversations, emails, and phone calls have occurred regarding budgets, operations, and IT development. CMS also conducted a review with Cover Oregon regarding its annual A-133 audit.

With respect to OHA, CMS's role in overseeing the use of federal funds included approval of the IAPD and also the IAPDU (June 2012 approval); quarterly System Development Lifecycle reviews (aka Gate Reviews); receipt of monthly high level budget to actual status reports also quarterly reports; and controlled releases of additional grant funds based on budget information supplied from OHA to CMS.

b. How did the state ensure the exchange IT build would be completed on schedule?

Cover Oregon's contract with its main development vendor Oracle expressly stated the production work required prior to October 1, 2013 to meet Cover Oregon's requirements to launch the website and the post production support required after October 1, 2013. Prior to Cover Oregon signing the contract in March 2013, the vendor assured Cover Oregon that the development plan and schedule would be met and the launch date would be achieved. Further, the Level of Effort estimates prepared by the main development vendor, upon which the contract was based, reflected that the website would be delivered prior to October 1, 2013.

The main developer vendor also provided demonstrations for federal gate reviews and to the Cover Oregon Board to demonstrate its progress. Up until mid-September 2013, the main development vendor continued to assure Cover Oregon of a timely completion and launch of the exchange, including during weekly status meetings.

10. Did the state conduct independent assessments on exchange readiness?

Yes. The State's contractor Maximus conducted Independent Validation & Verification (IV&V) assessments on a monthly basis before October 1, 2013. Copies of the Maximus reports have previously been provided to the Committee.

a. Who conducted the reports and when where they issued?

See above.

a. Who were the recipients of these readiness reports?

The Cover Oregon executive team received the Maximus reports.

11. When did the state first learn that the exchange build was behind schedule?

a. When did you first realize that your website would not be operational on October 1st?

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. Please see **Attachment 5** for a copy of the First Data report. While the State is still assessing the report's findings, the report does provide an analysis of issues related to the schedule [see **Attachment 5**, pages 37-38 and 57-68]. In summary, the report indicates that "[a]lthough there are numerous sources of documented communication regarding project status, scope issues, and concerns about system readiness, there does not appear to be a formal acceptance by the Cover Oregon leadership of issues significant enough to affect the success of the October 1 launch until August 2013. Even once the acceptance of those issues began in August, the delay in the system rollout was expected to be minimal. It was not until late October or November 2013 that the full extent of the delay was realized" [see **Attachment 5**, page 57].

b. When did you inform the federal government of your exchange's problems? Who did you inform?

In August 2013, Cover Oregon reported to CMS that some features of the website would be unavailable on October 1, 2013 and that it would be doing a soft launch. See, e.g., Oregon State Feedback Report Aug. 23, 2013 and Oregon State Feedback Report September 6, 2013, copies of which are attached to this report as **Attachments 6 and 7**. On August 8, 2013 Cover Oregon had a phone conference with CMS prior to the Cover Oregon Board meeting that day to notify CMS that Cover Oregon planned to announce that it anticipated only a soft launch on October 1. In addition, at the September 18 CMS Review, Cover Oregon discussed that on October 1, the public would be allowed access to the anonymous browse feature on the website, but would not be able to enroll and that community partners and agents would be allowed access to enroll clients.

12. Who was the central individual responsible for the exchange's development?

The main development vendor provided a Project Management Office and Chief Technical Officer responsible for the exchange's development. In addition, the project had a governance structure comparable to other large projects of its size--including an Executive Steering Committee, a Tactical Steering Committee, state and federal oversight bodies, and an independent quality assurance vendor; however, one theme highlighted by the First Data report was that the project lacked a single point of authority [see **Attachment 5**, pages 7-21].

a. Who decided whether to authorize the exchange to launch on October 1st?

The decision of whether to launch on October 1, 2013 rested with Rocky King, the Executive Director of Cover Oregon.

b. What was the date in which day one specifications were finalized?

In August 2013, Cover Oregon announced that the site would launch first to community partners and agents, and that they would be able to enroll individuals and small businesses. On October 1, Cover Oregon launched parts of the exchange related to community partners and agents. Please see **Attachments 8 and 9** for press releases that indicate what Cover Oregon had originally intended to launch and what actually launched on October 1.

c. Who made the final decision what features would launch on October 1st?

The decision of what to launch on October 1, 2013 rested with Rocky King, the Executive Director of Cover Oregon.

13. To date, what has the state done to identify the causes of the exchange's failure on October 1st? To date, who has been held accountable for the failures experienced on October 1st? How were they held accountable?

While Cover Oregon and OHA stabilize and transition the exchange, Oregon has a standstill agreement with its main development vendor. Oregon has retained outside counsel to review the relationship with this vendor.

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. See **Attachment 5**. While the State is still assessing the report's findings, the report does provide an analysis of issues related to oversight and governance accountability; decision making; scope management; and other issues related to the exchange's inability to completely launch on October 1.

There are a number of new executives who have been brought into Cover Oregon to offer their areas of expertise including retaining Clyde Hamstreet and Hamstreet & Associates to provide financial, advisory, and restructuring services to Cover Oregon; Alex Pettit, State of Oregon Chief Information Officer, to serve as interim CIO for Cover Oregon; and Tina Edlund, Director of OHA, and Sarah Miller, State of Oregon Deputy Chief Operating Officer, to lead the transfer QHPs to the federal technology and leverage current technology for Medicaid enrollments at OHA.

14. To date, how many people enrolled in private plans on your state exchange?

To date, there have been approximately 383,000 enrollments through Cover Oregon and the Oregon Health Authority. About 75,000 commercial enrollments and 193,000 Medicaid enrollments came through Cover Oregon. The rest of the Medicaid enrollments came directly through the Oregon Health Authority.

15. To date, how many of those enrollees have paid their first months' premium?

Cover Oregon does not yet have reliable data on how many enrollees have paid their first month's premium.

16. To date, how many of those enrollees had previously been insured?

Cover Oregon does not ask applicants this question on their application so we do not collect this data.

17. How many individuals were hired to process paper applications because the website did not work? How much did this cost? Was it paid for by federal or state funds?

Cover Oregon and OHA staff and temporary staff continue to provide services for 2014 enrollment efforts. OHA employed 209 temporary employees to help process paper applications, which equaled $7,004,092 in expenditures through April 30, 2014. OHA estimates this to be approximately $4.06 million in federal funds and $2.94 million in state funds. Temporary staff were also hired by Cover Oregon. As of April 30, the total spent by Cover Oregon was $2.9 million, and included 126 temporary staff.

18. What percentage of the originally planned features of the system was expected to be functional on October 1st?

Prior to May 2013, Cover Oregon expected 100% of its planned features to be functional October 1, 2013. Although the plan was to launch the website so that individuals and small business owners could enroll on their own in one sitting beginning in May 2013, Cover Oregon, in conjunction with its main development vendor, began to analyze a reduction of scope for the exchange to ensure the October 1, 2013 launch. In July 2013, Cover Oregon, in conjunction with its main development vendor, decided to reduce scope. In August 2013, Cover Oregon announced that the site would launch first to community partners and agents, and who would be able to enroll individuals and small businesses. See **Attachments 8 and 9** for press releases that indicated what Cover Oregon had originally intended to launch and what actually launched on October 1.

a. What percentage of the originally planned features of the system was actually functional on October 1st?

Community partners and agents could start an application in the system for consumers. See **Attachments 8 and 9** for press releases that indicate what Cover Oregon had originally intended to launch and what actually launched on October 1.

b. What percentage of the originally planned features of the system is functioning currently?

Community partners and agents can submit applications on behalf of consumers and enroll those consumers from start to finish. Individual consumers cannot enroll on their own. Development of the small business program is on hold.

c. What functions remain to be built?

As of April 25, 2014, the Cover Oregon Board of Directors decided to stop further development on the current state website for private health insurance. Instead, beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology to sign people up for private plans. In addition the small business program has not been built yet and the alternatives for providing SHOP are currently being discussed. Although functions such as individual enrollment and eligibility have been built, the functionality has not yet been fully optimized for public use.

19. Prior to October 1st, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped? How was the public made aware of these changes?

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. See **Attachment 5**. While the State is still assessing the report's findings, the report does provide an analysis of issues related to the project scope [see **Attachment 5**, pages 44-54].

During the timeframe beginning in July 2013, adjustments to the launch strategy were made by Cover Oregon following a progressive sequence of limiting the functions that would go live. A broad overview of features descoped includes:

- May 2013 – Cover Oregon, in conjunction with its main development vendor, began analyzing scope reduction.
- July 2013 – Cover Oregon, in conjunction with its main development vendor, decided to reduce scope.
- August 2013 – Cover Oregon announced it would execute a "soft launch," the user audience limited to agents and community partners.
- Late September 2013 – SHOP release put on hold.
- Late September 2013 – Initial rollout limited to the first 5-6 pages of the application.
- November 2013 – No individual portal launch.

See **Attachments 8 and 9** for press releases that indicate what Cover Oregon had originally intended to launch and what actually launched on October 1.

20. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)

There was no one person who held the title of program manager for the exchange. For an organizational chart of the exchange's management, see the First Data report, **Attachment 5**, page 20. If the Committee has specific questions about particular positions within the exchange or the people who held those positions, the State is happy to provide additional information.

21. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. See **Attachment 5**. While the State is still assessing the report's findings, the report does provide an analysis of issues related to project staff and oversight.

22. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. See **Attachment 5**. While the State is still assessing the report's findings, the report does provide an analysis of issues related to the exchange's main development vendor. The First Data Report also cites Maximus QA reports and a Siebel Assessment Report prepared by Cover Oregon which raises concerns about the exchange's main development vendor [see **Attachment 5**, pages 37-38 & 59].

CMS provided a technical assistance report dated February 27, 2014, which also discusses issues related to the exchange's main development vendor. Please see **Attachment 10** for a copy of the CMS technical assistance report.

Cover Oregon and the State have retained outside counsel who is working with the Oregon Department of Justice to review liability issues related to the exchange. We are not in a position to answer this question more fully in light of the need to preserve attorney client privilege.

23. According to documents reviewed by the Committee, it appears that the Oregon exchange did not conduct an independent security assessment of their system prior to receiving an Authority to Connect from CMS. Why did the state not conduct an independent security assessment of their system? Does the state plan to conduct an independent assessment of their exchange system? If so, when?

Cover Oregon met all federally required security protocols and reported them appropriately. Cover Oregon performed a significant portion of the independent assessment due to CMS on March 31, 2014 prior to that date and provided that information to CMS on September 12, 2013. Cover Oregon has never received a federal "high risk" security assessment.

Specific requirements included:

- **CMS-required System Security Plan** – The final plan was due prior to getting authority to connect (ATC) to the federal hub. Cover Oregon submitted the final SSP to CMS on September 10, 2013. Authority to Connect was granted on September 27, 2013. Please see **Attachment 11** for a copy of the CMS approval.

- **IRS-required Security Procedures Report** – The final report was due prior to getting authority to connect to the federal hub from IRS to access federal tax information. Cover Oregon submitted it to IRS on September 10, 2013. Approval from the IRS was granted on September 20, 2013. Please see **Attachment 12** for a copy of the IRS approval.

- **Independent Security Assessment Report** – Due on March 31, 2014. Maximus was the vendor for this. This assessment report was partially completed by Maximus on September 12, 2013 before connecting to the federal hub and was fully completed by March 31, 2014 and submitted to CMS on March 31, 2014. The partial assessment focused primarily around the protections for federal tax information, which is the most sensitive data held in the exchange and showed that Cover Oregon had necessary and appropriate protections in place for secured information.

24. In the November 2012 Cover Oregon monthly status report, a year before the site was supposed to launch, Cover Oregon acknowledged the "[f]inal deadline of 10/1/2013 continues to be of high concern." What action was taken to address this "high concern?"

Over the course of the next year, steps were taken to address concerns about the progress of the IT build, including the addition of new staff and contractors with specific expertise, descoping of the project, and a phased launch plan.

25. A review of the Oregon exchange conducted by MITRE found there was "no overarching dedicated Project Manager who should be responsible for overseeing the project to drive overall project activities and keep everyone on track with targeted deliverables." When did the state and exchange employees become aware of concerns that the project lacked "an overarching dedicated Project Manager who should be responsible for overseeing the project?" What actions have been taken to fix these problems?

In December 2013, when the main development vendor was unable to repair the website, Cover Oregon stopped payment to that vendor. The Governor also brought the director of OHA, Bruce Goldberg, to be the acting director of Cover Oregon after the Cover Oregon director, Rocky King took medical leave and ultimately resigned.

Since that time, there are a number of new executives who have been brought into Cover Oregon to offer their areas of expertise including retaining Clyde Hamstreet and Hamstreet & Associates to provide financial, advisory, and restructuring services to Cover Oregon; Alex Pettit, State of Oregon Chief Information Officer, to serve as interim CIO for Cover Oregon; and Tina Edlund, Director of OHA, and Sarah Miller, State of Oregon Deputy Chief Operating Officer, to lead the transfer QHPs to the federal technology and leverage current technology for Medicaid enrollments at OHA.

In January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. See **Attachment 5**. While the State is still assessing the report's findings, the report does

provide an analysis of issues related to oversight of the project and identified the theme that the project lacked a single point of authority. See response to Question 12 above.

Moving forward, on April 25, 2014, the Cover Oregon Board of Directors decided to stop further development on the current state website for private health insurance. Instead, beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology to sign people up for private plans. In addition the small business program has not been built yet and plans to build this are currently being discussed.

See response to Question 13 above for more information on actions that have been taken.

26. MITRE also noted "system environments are not stable and are affecting testing, development and activities." When did state employees become aware that "system environments were not stable?" What actions have been taken to fix these problems? How is the state able to adequately test the security of the system when its environments are not stable?

State employees became aware that the production environment was not stable during a late September 2013 demonstration by Cover Oregon's main development vendor just prior to launch. Despite continued work, Cover Oregon's main development vendor was never able to stabilize the production environment. As of April 25, 2014, the Cover Oregon Board of Directors decided to stop further development on the current state website for private health insurance. Instead, beginning with the November 2014 open enrollment period, Cover Oregon will use the federal exchange technology to sign people up for private plans. The current system passed security reviews. See response to Question 23 above.

27. MITRE reports that "[t]here is no evidence that CO [Cover Oregon] has established good contract administration processes, or that OCS' [Oracle Consulting Services] activities are being closely monitored to make sure that they are fulfilling the requirements of the contract." When did state employees become aware that there were concerns over the oversight of contractors? What actions have been taken to fix these problems?

Cover Oregon had in place a quality control/quality assurance vendor, as well as Independent Validation + Verification (IV&V) to monitor contractors and make sure they were fulfilling contract obligations.

With respect to the Oracle Consulting Services (OCS) contract in particular, in January 2014, the State contracted with First Data to provide an independent review of the development and other issues related to the exchange. First Data issued its report in March 2014. While the State is still assessing the report's findings, the report does provide an analysis of issues related to the OCS contract. See **Attachment 5**, pages 37-38.

In December 2012, when the main development vendor was unable to repair the website, Cover Oregon stopped payment to that vendor. As discussed elsewhere, the Governor brought in Dr. Goldberg as acting director of Cover Oregon and a number of new executives have been brought into Cover Oregon.

Cover Oregon and the State have retained outside counsel who is working with the Oregon Department of Justice to review liability issues related to the exchange. We are not in a position to answer this question more fully in light of the need to preserve attorney client privilege.

28. Maximus, a contractor hired to monthly quality assessment reports for the exchange has consistently reported the overall health of the exchange as a high risk going back to 2011. Which individuals, employed both by the state and the exchange, received these reports?

With respect to Cover Oregon, Rocky King, Aaron Karjala, Triz delaRosa, Nora Leibowitz, and Amy Fauver (and Amy Shelton when she came to Cover Oregon in June of 2013) received Cover Oregon's Maximus reports. In addition, the Cover Oregon Board of Directors, Legislative Fiscal Oversight Committee members, Bob Cummings, and Ying Kwong also received Cover Oregon's Maximus reports.

With respect to OHA, the individuals who received QA reports at various times throughout the life of the project include: Bruce Goldberg, OHA Director; Carolyn Lawson, OHA/DHS Chief Information Officer; Steve Powell, Deputy CIO; Amy Shelton/Pete Mallord, Project Manager; Monte Burke/Rus Hargrave, Project Directors; and Ying Kwong and Julie Pearson-Ruthven Department of Administrative Services Office of the CIO.

a. How were the concerns identified in these reports communicated to CMS?

Cover Oregon Maximus QA reports were provided to CMS on a monthly basis as received. With respect to OHA, risk information derived from the Maximus QA reports were included in the monthly CMS reports created by the project manager.

b. What was done to address the concerns raised in these independent reports?

With respect to Cover Oregon, many of the concerns laid out in the reports were addressed. How each was addressed was reflected in the reports themselves. Each "Priority QA Recommendation" is listed alongside a "CO Response." With respect to OHA, response and/or risk mitigation were included with each risk/issue identified.

29. According to press reports published in *The Oregonian*, Ying Kwong, an IT analyst, warned Oregon officials in May that "Cover Oregon's managers were being 'intellectually dishonest' in claiming the project would be ready Oct. 1." How did the state address Mr. Kwong's concerns?

It appears that the email referenced in the *Oregonian* article was an exchange between Mr. Kwong, a Department of Administrative Services IT analyst, and Bob Cummings, staff in the Legislative Fiscal Office. No one from Cover Oregon management was copied on the email. Regardless, around the time of this email, Cover Oregon, with its main development vendor, reviewed and reduced scope. See responses to Questions 11 and 19.

30. Were concerns about exchange not being ready on October 1st communicated to CMS?

See response to Question 11 above.

31. Also according to *The Oregonian*, in May 2013, former executive director Rocky King wrote interim director Bruce Goldberg that the federal officials asked questions that were "neither 'tough' nor very relevant." Mr. King wrote: "Behind the eight ball as we are… I think our federal partners were impressed." Did exchange officials downplay concerns to federal officials that the exchange would be operational on October 1st?

Please see **Attachment 13** for a copy of the May 31, 2013 email referenced in Question 31. That email includes the 106-slide presentation of the May 30, 2013 Final Detailed Design Review. This review reflected the status of the exchange as of that date. A copy of this presentation was produced to the committee in Oregon's May 2, 2014 production of documents. Exchange officials did not downplay concerns to federal officials that the exchange would be operational on October 1. As discussed elsewhere in this letter, the State reduced scope, and in August 2013, the State began to report some features of the website that would not be available on October 1.

Questions related to this response can be directed to me at (503) 580-6059/ liani.reeves@state.or.us or Elliot Berke at (202) 828-2814/eberke@mcguirewoods.com.

Sincerely,

Liani J. Reeves
General Counsel,
Office of the Governor

cc:
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Minority Staff
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Response to Questions from Chairman Jordan and Chairman Lankford
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
Subcommittee on Energy Policy, Health Care and Entitlements

1. To date, how much money has the state received in establishment grants to set up a health insurance exchange?

   The Hawaii Health Connector (Connector) has received approximately $204 million in establishment grants. Further details can be found here: http://www.cms.gov/CCIIO/Resources/Marketplace-Grants/hi.html

   a. Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?

      To date, the Connector has received no additional funding from any other source other than issuer fees through a 2 percent fee levied against all individual plans (starting January 1, 2014) inside the Connector. Additional funds are anticipated from a 2 percent fee levied against all Small Health Options Program plans (starting July 1, 2014) inside the Connector.

   b. How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?

      The Connector has spent $75.1 million on the development of the exchange program and related IT systems as of March 31, 2014.

   c. How much has the exchange obligated to spend, but has not yet been spent on exchange development?

      The Connector has obligated $44.9 million on the development of the exchange program and related IT systems as of March 31, 2014.

   d. Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?

      The Connector does not currently plan to request additional federal funds beyond those funds that have been approved through the establishment grant application process.

2. Please provide the list of all contracts awarded to develop the exchange

and its related systems, including the following information for each contract:

Please see the attached contract schedule for all IT and program-related contracts greater than $500,000. (See Items a-f.)

a. When was the contract awarded?

Please see the attached Contract Schedule.

b. What was the ceiling value of the contract and how much did the vendors receive to date?

Please see the attached Contract Schedule.

c. Was the contract competitively bid or sole sourced?

Please see the attached Contract Schedule.

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

Please see the attached Contract Schedule.

e. Who is the responsible official for overseeing the contract?

Please see the attached Contract Schedule.

f. How many contract modifications were made from the start of the contract?

Please see the attached Contract Schedule.

Under the contract terms and conditions, who is financially responsible for fixing problems with the system?

The contract provides specified remedies, in the event that either party raises a problem or a violation of those terms of conditions has been identified.

3. Does the exchange plan to continue with the current contractors or terminate and replace with more capable vendors? If the exchange decides to award new contracts, will all new contracts be awarded through competitive bids?

The Connector is committed to providing the residents of Hawaii the best value through expenditures of federal funds and those funds raised through the fees discussed above. The Connector Board has also established a procurement policy which is available online to the public to outline the rules which it follows before awarding any significant contracts.

Please see the following: http://www.hawaiihealthconnector.com/wp-content/uploads/oarchive/Hawaii_Health_Connector_-_Procurement_Policy.pdf

4. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?

   The Connector modifies contracts when there is a substantive change in the terms or conditions of the agreement or the Connector requires that different or additional work must be completed that are essential to the success of the Connector. These modifications were made to further the mission and goals of the Connector, including but not limited to increasing enrollments, improving the consumer experience and meeting the standards to be a federally compliant marketplace.

5. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

   The Connector cannot currently estimate what funding it might need to fix potential problems in the future. At this time the Connector does not expect to request additional funding to build its health insurance marketplace.

6. To date, how much has the state or the exchange spent on advertisements publicizing the law and/or the exchange?

   The Connector has spent $2.9 million through March 31, 2014.

   Did the state or the exchange use federal or state funds?

   Yes. As authorized in our approved grant application, the Connector used Federal funds.

7. After September 30, 2013, approximately how much has been paid in bonuses to exchange employees?

   Through September 30, 2013 approximately $28,000 has been paid in bonuses.

8. What are the estimated operational costs for the exchange in the years 2014,2015, and 2016?

   Calendar Year 2014: See attachment
   Calendar Year 2015: See attachment
   Calendar Year 2016: See attachment

   a. What revenue sources will the state utilize to finance the exchange in these years?

      The issuer fees of 2 percent on the premiums of the policies issued by the Connector (individual market begins January 1, 2014 and SHOP market begins July 1, 2014).

      What is the expected revenue?

      Expected revenue is as follows:

      Calendar Year 2014: See attachment
      Calendar Year 2015: See attachment
      Calendar Year 2016: See attachment

   b. How will the state address any deficits in the exchange's budget?

      Should the Connector not be able to achieve sustainability, the legislature may appropriate $1.5 million, subject to signature of the Governor.

      The Connector is also working with the Governor's Office, the Insurance Division of the Department of Consumer and Commerce Affairs, the Department of Labor and Industrial Relations and the Department of Human Services (State Medicaid Agency).

   c. Will the state seek any federal money to help finance the exchange's operations?

      The Connector will continue to work with the grants division of CMS to ensure that all spending aligns with appropriate policies as defined in the HHS grants policy statement.

9. Who was the state's primary point of contact at CMS?

    a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? What was the role?

    CMS played the primary role in overseeing the use of federal funds. The Connector worked with several divisions, including the Center for Consumer Information and Insurance Oversight (CCIIO), the Office of Information Systems (OIS) the Center for CHIP and Medicaid Services (CMCS). The Connector's primary point of contact was CCIIO.

    b. How did the state ensure the exchange IT build would be completed on schedule?

    The Connector worked closely with several divisions across the state administration. This included the Governor's Office, the Office of Information and Management of Technology, and the Department of Human Services.

10. Did the state conduct independent assessments on exchange readiness?

    The state continued to monitor progress and the Connector worked with its Independent Verification and Validation (IV&V) vendor to continually assess readiness and prioritize to meet October 1, 2013 open enrollment.

    a. Who conducted the reports and when where they issued?

    The IV&V vendor provides reports on a regular basis as defined through tis contract with the Connector.

    b. Who were the recipients of these readiness reports?

    The Connector, its IT vendor, CMS, and the state were the recipients of the report.

11. When did the state first learn that the exchange build was behind schedule?

    To our knowledge, the decision to delay some functionalities of the launch was made on September 20, 2013.

    a. When did you first realize that your website would not be operational on October 1st?

    The Connector monitored progress until the day before open enrollment and opted to not "go-live" for reasons relating to potentially compromised

user experience and a possible security issue. The Connector immediately invoked its contingency option and launched a more complete functionality on October 15, 2014.

b. When did you inform the federal government of your exchange's problems? Who did you inform?

The Connector was in regular contact with CMS at the contacts listed above. We do not have direct knowledge of the precise timing of when then-Executive Director Coral Andrews notified CMS.

12. Who was the central individual responsible for the exchange's development?

a. Who decided whether to authorize the exchange to launch on October 1st?

Then-Executive Director, Coral Andrews.

b. What was the date in which day one specifications were finalized?

Day one specifications were adjusted as changes were made to both the project plan and requirements to provide for a functioning marketplace.

c. Who made the final decision what features would launch on October 1?

Then-Executive Director, Coral Andrews.

13. To date, what has the state done to identify the causes of the exchange's failure on October 1st? To date, who has been held accountable for the failures experienced on October 1st? How were they held accountable?

We would refer questions regarding state activities to the Governor's office, as the Connector is a non-profit entity. However, with respect to actions taken by the Exchange, we note that the Connector strongly believes in lessons learned. We have continued to evaluate what could be done better and how to make the marketplace more efficient.

14. To date, how many people enrolled in private plans on your state exchange?

Through May 1, 2014, 9,789 individuals and families have enrolled in private plans.

15. To date, how many of those enrollees have paid their first months' premium?

The Connector is continuing to collect this data and will provide updated figures to the Committee as available.

16. To date, how many of those enrollees had previously been insured?

Unknown.

17. How many individuals were hired to process paper applications because the website did not work? How much did this cost? Was it paid for by federal or state funds?

The Connector used its existing staff (marketplace assisters), internal staff and the Contact Center vendors to supplement the processing of paper applications. No new hires were made. In addition, initial intake for all individual or family applicants interested in the Premium Tax Credits or Medicaid goes through the state Medicaid agency.

18. What percentage of the originally planned features of the system was expected to be functional on October 1st?

54%

a. What percentage of the originally planned features of the system was actually functional on October 1st?

The Connector delayed its initial October 1, 2013 launch to October 15, 2013, when a significant larger percentage was delivered and functional.

b. What percentage of the originally planned features of the system is functioning currently?

Approximately 65%.

c. What functions remain to be built?

- *Change of Circumstance*
- *834s*

- *Renewals*
- *Disenrollment*
- *Document upload*
- *Appeals/Complaints*
- *Turn on Notifications*
- *RIDP*
- *Data Warehouse*
- *Additional Consumer Usability Improvements and Performance Enhancements*

19. Prior to October 1st, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped? How was the public made aware of these changes?

Yes. The change in architecture in July 2013 led to a contract Amendment that established a phased deployment to spread the functionality over three planned releases to occur from October 1, 2013 to March 31, 2014.

Approximately 1 week prior to October 1 (on or about September 24) it was determined that the Plan Presentment, Plan Selection, and Enrollment functions for Individuals and Families would not be available. The remaining functions were expected to be available approximately 10 days later. Due to other technical difficulties, the full planned Release 1 was deployed Oct 15.

20. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)

Acting CIO, Anjali Kataria (December 1, 2013 – Present) possesses the necessary technical expertise for enterprise software design, development and implementation.
CGI Project Manager – Nick Harrigan

21. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?

The Connector continually evaluates staff performance and recruits skilled professional who have the appropriate level of experience.

21. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?

The Connector urged the contractor to continually improve the level of expertise on the group it used to support the Connector.

Hawaii Health Connector
Schedule of Information Technology and Contact Center Contracts
As of March 31, 2014

Date Awarded	Contractor	Contract Amount	Procurement Method	Contract Type	Responsible Official	# of Contract Modifications
11/12/12	CGI Technologies and Solutions, Inc.	$ 63,865,464	Competitive Bid	Fixed	CIO	4
4/13/12	Public Consulting Group, Inc.	$ 5,100,330	Competitive Bid	T&M	COO	5
1/16/13	Turning Point Global Solutions, LLC	$ 2,351,821	Competitive Bid	T&M	CIO	1
11/30/12	Milici, Valenti, Ng, Pack, Inc	$ 1,992,815	Competitive Bid	T&M	CMO	1
4/26/13	Mansha Consulting	$ 21,420,017	Sole Source	Fixed	CIO / Exec Dir	3
1/1/2014	Public Consulting Group, Inc.	$ 650,000	Sole Source	T&M	CIO	0
6/6/13	Maximums Health Services, Inc.	$ 9,692,081	Competitive Bid	Fixed	COO	3
8/1/2013	Oahu Publications	$ 1,200,000	Sole Source	T&M	CMO	0
11/2/2013	Kataria Holdings LLC	$ 580,000	Sole Source	T&M	Exec Dir	3

Responsible Official	# of Contract Modifications
CIO	4
COO	5
CIO	1
CMO	1
CIO / Exec Dir	3
CIO	0
COO	3
CMO	0
Exec Dir	3

Hawaii Health Connector
Budget and Forecast
For the Years Ended December 31, 2014, 2015, & 2016

	CY 2014 Budget	CY 2015 Forecast	CY 2016 Forecast
Support and Revenue:			
Federal Grants	$ 91,213,321	$ 9,692,849	$ -
State Appropriation	-	1,500,000	-
Issuer Fees	469,761	2,584,160	3,962,875
Total Support and Revenue	91,683,081	13,777,009	3,962,875
Expenditures			
Personnel Costs	5,365,290	3,418,026	2,540,628
IT Contracts (including costs to be capitalized)	66,972,420	12,905,613	4,757,889
State DHS Cost Allocation to Connector	7,161,283	768,000	694,785
Non-IT Contracts	20,714,532	5,520,000	2,440,000
Less: Costs to be Allocated to Medicaid	(11,043,536)	(1,884,169)	(200,000)
Equipment	535,580	35,000	20,000
Travel	170,080	75,000	50,000
Supplies	60,051	22,500	15,000
Other-Facilities and Administration	888,859	684,329	595,600
Total Expenditures	90,824,558	21,544,298	10,913,902
Total Support and Revenue Over (Under) Expenditures	$ 858,523	$ (7,767,289)	$ (6,951,026)

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Response to Committee Questions

The Maryland Health Benefit Exchange has made best efforts to answer the Committee's questions based on its understanding of the questions, its business records, and knowledge of its current staff. The Maryland Health Benefit Exchange has not completed its investigation into the subject matter of these responses. Accordingly, new or different information may be developed in the course of the investigation. If inadvertent errors or omissions are found to exist in these responses, they are subject to correction.

1. **To date, how much money has the state received in establishment grants to set up a health insurance exchange?**

As of March 26, 2014, the state has received $182.2 million in establishment grants to set up the Maryland Health Benefit Exchange.

a. **Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?**

Yes, as of March 26, 2014, we have received $12.8 million in federal financial participation for the state Medicaid program related to the development of Maryland Health Benefit Exchange systems.

b. **How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?**

As of March 26, 2014, we have spent $118.8 million in federal funds for the Maryland Health Benefit Exchange, including its related IT systems. This includes all costs, including staff, rent, outreach and marketing, etc. -- in addition to IT.

c. **How much has the exchange obligated to spend, but has not yet been spent on exchange development?**

With respect to IT, we are evaluating our budget needs in light of a recent decision to upgrade our website using Connecticut's technology.

d. **Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?**

We are in the process of identifying ways to repurpose previously awarded grant dollars to fix problems with our current system and upgrade the technology as planned. We do expect additional funds to be necessary, and we will work with CMS to finalize the amount and develop a plan for these funds.

2. Please provide the list of all contracts awarded to develop the exchange and its related systems, including the following information for each contract:

Please see Attachment 1 for the list, and corresponding information requested below, of all contracts awarded to develop the Maryland Health Benefit Exchange and its related systems.

a. When was the contract awarded?

b. What was the ceiling value of the contract and how much did the vendors receive to date?

Information on how much each vendor has received to date was not available by the deadline for submission of these responses. The responses will be supplemented when this information becomes available.

c. Was the contract competitively bid or sole sourced?

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

e. Who is the responsible official for overseeing the contract?

f. How many contract modifications were made from the start of the contract?

If there was a contract modification, there is another record for the vendor and it will indicate that it is a task order in Attachment 1.

g. Under the contract terms and conditions, who is financially responsible for fixing problems with the system?

Under the contract between the Maryland Health Benefit Exchange and Noridian, Noridian was responsible for delivering an operational system by, at latest, October 1, 2013, and for fixing problems with the system.

3. Does the exchange plan to continue with the current contractors or terminate and replace with more capable vendors? If the exchange decides to award new contracts, will all new contracts be awarded through competitive bids?

On February 24, 2014, the Maryland Health Benefit Exchange terminated its contract with Noridian, its prime contractor. The current prime contractor is Optum/QSSI, the same company assisting the federal government with healthcare.gov. In addition, on April 1, 2014, the Maryland Health Benefit Exchange Board voted to upgrade the current website technology using Connecticut's system. The Exchange has hired Deloitte LLP for this implementation. Both the Optum/QSSI and Deloitte LLP contracts were issued on an emergency basis, consistent with the procurement policy of the Maryland Health Benefit Exchange.

4. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?

On November 29, 2013, the Maryland Health Benefit Exchange approved a contract modification to Noridian's contract to provide several discrete services to their contract. These services included hiring training specialists, implementing a staging environment, installing a software monitoring tool, and purchasing licenses related to the call center.

In addition, contract modifications to the Optum contract have been issued for maintenance and operations; hosting; expanded IT support; expanded operational support; design, development and implementation; and specialized EDI services.

5. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

The Maryland Health Benefit Exchange is in the process of identifying ways to repurpose previously awarded grant dollars to fix problems with our current system and upgrade the technology as planned. We do expect additional funds to be necessary, and we will work with CMS to finalize the amount and develop a plan for these funds.

6. To date, how much has the state or the exchange spent on advertisements publicizing the law and/or the exchange? Did the state or the exchange use federal or state funds?

As of March 26, 2014, $6.2 million, including both federal and state funds.

7. After September 31, 2013, approximately how much has been paid in bonuses to exchange employees?

None.

8. What are the estimated operational costs for the exchange in the years 2014, 2015, and 2016?

The FY 2014 budget is $153.4 million, which is inclusive of the deficiency appropriation but exclusive of any remaining FY 2013 encumbrances, which currently appear to be marginal. The FY 2015 budget is currently $72 million. For 2016, the costs have been estimated at about $40 million, but the budget has not been finalized or submitted through the budget process.

a. What revenue sources will the state utilize to finance the exchange in these years? What is the expected revenue?

The revenue sources will include the establishment grants (as permitted), the Medicaid program (as permitted), state general funds, and revenue from an insurance assessment on state-regulated plans. The balance between budget and revenue is set during the state budget process.

b. How will the state address any deficits in the exchange's budget?

The State will address deficits through the budget process.

c. Will the state seek any federal money to help finance the exchange's operations?

The State will seek to finance the Maryland Health Benefit Exchange's operation through permitted federal, state, and other funding sources. The availability of certain federal funds changes over time, and the State will comply with these restrictions.

9. Who was the state's primary point of contact at CMS?

Amanda Cowley

a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? What was the role?

The grant award is a cooperative agreement which involves significant federal involvement. CMS's role in overseeing the federal funds began early in the application review process. We began engaging with CMS during a budget negotiation process that included a series of questions and responses from their subject matter experts.

After the grant was awarded, CMS monitored the use of federal funds. As part of the terms and conditions of awards, states must submit semi-annual progress reports and monthly budget summaries. These reports help CMS monitor progress and identify technical assistance needs.

In addition, we participate in Marketplace Establishment Reviews, consisting of face-to-face meetings with the State and the CMS policy and operations teams.

b. How did the state ensure the exchange IT build would be completed on schedule?

The State maintained a schedule and established a project management office to support the build of the Maryland Health Benefit Exchange. As our testimony to the Committee indicates, however, there were significant gaps in the software at the time of the launch. As the attached testimony to the Maryland General Assembly explains in detail, software products that were sold to Maryland as ready out of the box actually were defective and deficient (Attachment 2).

10. Did the state conduct independent assessments on exchange readiness?

a. Who conducted the reports and when where they issued?

b. Who were the recipients of these readiness reports?

The State did not conduct an independent assessment of the Maryland Health Benefit Exchange readiness outside of project management and independent verification and validation reports.

11. When did the state first learn that the exchange build was behind schedule?

The independent validation and verification reports, the executive summaries of which are attached to the first testimony to the Maryland General Assembly (Attachment 2), document concerns about the schedule. As the reports indicate, the state responded to these concerns in several ways.

a. When did you first realize that your website would not be operational on October 1st?

The events prior to October 1 are described in testimony to the Maryland General Assembly on January 14, 2014, pages 8-9 (Attachment 2).

b. When did you inform the federal government of your exchange's problems? Who did you inform?

There were multiple conversations with federal officials from several agencies about the state of readiness prior to October 1, 2013. Pages 8 and 9 of the state testimony from January 14 describes our understanding of the state of readiness prior to October 1, 2013 (Attachment 2).

12. Who was the central individual responsible for the exchange's development?

The IT project was jointly overseen by the Maryland Health Benefit Exchange, the Department of Health and Mental Hygiene, and the Department of Human Resources. From March to

October 2013, the lead person overseeing the IT project was the executive director of the Maryland Health Benefit Exchange.

a. Who decided whether to authorize the exchange to launch on October 1st?

The events prior to October 1, 2013 are described in testimony to the Maryland General Assembly on January 14, 2014, pages 8-9 (Attachment 2).

b. What was the date in which day one specifications were finalized?

Our plan for October 1, 2013 was finalized shortly prior to October 1, 2013.

c. Who made the final decision what features would launch on October 1st?

The events prior to October 1, 2013 are described in testimony to the Maryland General Assembly on January 14, 2014, pages 8-9 (Attachment 2).

13. To date, what has the state done to identify the causes of the exchange's failure on October 1st? To date, who has been held accountable for the failures experienced on October 1st? How were they held accountable?

We have described the causes of the IT problems in testimonies to Maryland General Assembly on January 14, February 10, and February 24, 2014 (Attachments 2, 3, and 4).

We have terminated our relationship with our prime contractor Noridian. We are not able to comment further on personnel matters.

14. To date, how many people enrolled in private plans on your state exchange?

The most recent enrollment data was released last week by CMS's Assistant Secretary for Planning and Evaluation.

15. To date, how many of those enrollees have paid their first month's' premium?

As of April 24, 2014, 38,485 have paid their first month's' premium. Of note, many individuals have yet to receive a bill or faced a deadline for bill payment.

16. To date, how many of those enrollees had previously been insured?

We do not have reliable data on how many of these enrollees had been previously uninsured. However, many individuals with low incomes transition on and off insurance. So even if someone were insured immediately prior to obtaining coverage through the Maryland Health Benefit Exchange, that does not mean that person would have stayed insured for any specific

period of time. The long-term impact of the Affordable Care Act on insurance status in Maryland will become clear through the regular surveys conducted of insurance status.

17. How many individuals were hired to process paper applications because the website did not work? How much did this cost? Was it paid for by federal or state funds?

The Maryland Health Benefit Exchange Board tripled the number of call center customer servicers workers from 120 to 363 to meet the needs of Marylanders in enrolling for health coverage. Call center customer service representatives provide full scope of assistance by phone with eligibility determination and enrollment in Medicaid managed care organizations and qualified health plans.

The call center was paid for with federal and state funds. We testified on February 10, 2014 to the Maryland General Assembly that we anticipate spending an additional $6 million in call center activities (Attachment 3).

18. What percentage of the originally planned features of the system was expected to be functional on October 1st?

a. What percentage of the originally planned features of the system was actually functional on October 1st?

b. What percentage of the originally planned features of the system is functioning currently?

c. What functions remain to be built?

On October 1, 2013 we expected account creation, eligibility determination, and plan shopping to be functional. However, because of connectivity problems, little was functional on October 1, 2013. By the end of open enrollment, our IT system was able to handle account creation, eligibility determination, plan shopping, and enrollment. It has limited functionality for life events and notices. We are using manual workarounds for some of these functions. Our intention is not to complete development of the current system, and rather upgrade our technology using the Connecticut IT platform.

19. Prior to October 1st, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped? How was the public made aware of these changes?

Yes. For example, in the spring of 2013, the Maryland Health Benefit Exchange decided to delay the launch of the small business exchange. This was announced publicly at a board meeting. Prior to October 1, 2013 we were aware that enrollment information would not be sent to carriers right away. This was explained at a media event prior to the launch.

20. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)

Maryland's Secretary of the Department of Information Technology Isabel FitzGerald is leading the IT development. She has substantial experience in both the public and private sector in systems development.

21. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?

The Maryland Health Benefit Exchange has not to date concluded that any of its employees involved in overseeing the contractors responsible for developing the Maryland Health Benefit Exchange's IT system lacked adequate technical skills to fulfill these responsibilities.

22. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?

The Maryland Health Benefit Exchange is reviewing the performance of the contractors retained to develop the IT system, including the adequacy of their technical skills, in connection with the possible assertion of claims for nonperformance. Since the system's launch on October 1, 2013, the Maryland Health Benefit Exchange has retained new contractors to supplement the efforts of existing contractors, and, on February 24, 2014, the Maryland Health Benefit Exchange terminated its contract with Noridian, its prime IT contractor.

23. According to the Baltimore Sun, Maryland will scrap their current exchange system and modify an existing system developed by the state of Connecticut. The *Baltimore Sun* reports that the transition would cost between $40 and 50 million.

a. How does the state intend to finance this transition to a new system?

The State intends to finance this transition through both federal and state funds.

i. Does the state intend to apply for additional federal grants? If so, how much?

We are in the process of identifying ways to repurpose previously awarded grant dollars to fix problems with our current system and upgrade the technology as planned. We do expect

additional funds to be necessary, and we will work with CMS to finalize the amount and develop a plan for these funds.

b. Will the contractors hired to develop the new system be chosen through a competitive process?

The process used to hire Deloitte to develop the new system was described in a memo to the Maryland Health Benefit Exchange Board dated March 31, 2014 (Attachment 5). Specifically, proposals were sought from two companies. One company declined to submit a bid. The other company (Deloitte) submitted a bid with the understanding it was a competitive process.

24. According to the Committee's review of a state budget analysis, Maryland has used federal Medicaid funds for the exchange development. Approximately how much in Medicaid spending, federal and state, has been spent to develop the exchange and its related systems?

As of March 26, 2014, approximately $39 million in Medicaid funds, federal and state, has been spent for IT development and other related systems. (Not all of the federal funding has been received, which explains the difference from Question 1a).

a. The state budget analysis further states that "[w]hen MHBE has to be self-financing, the availability of federal funds through the Medicaid match to support ongoing operations will lower overall need for an alternative funding source." How much in federal Medicaid funds does the state intend to utilize to finance the operations of the exchange and its related systems after Jan. 1, 2015?

Our budget for state fiscal year 2015 estimates that the first six months of 2015 will include $5.6 million in federal Medicaid funds. This may be modified through appropriate processes. We will build the following year's budget this summer for submission to the General Assembly in January 2015.

b. The heading for Section 1311(d)(5) of the Patient Protection and Affordable Care Act reads "no federal funds for continued operations." In other words, exchanges are supposed to be self sufficient. How can the state's plan to utilize federal Medicaid funds be reconciled with a clear restriction on the use of federal funds for continued exchange operations after 2015?

Section 1311(d)(5) of the Patient Protection and Affordable Care Act requires that the Maryland Health Benefit Exchange be "self-sustaining" after 2015. Maryland's Medicaid program has, through a memorandum of understanding, delegated certain responsibilities to the Maryland Health Benefit Exchange to perform certain functions on the Medicaid program's behalf. These functions are not necessary for "continued operations" of the Maryland Health Benefit

Exchange. Neither Section 1311(d)(5) nor any other federal law prohibits the use of federal and State Medicaid funds for the performance of Medicaid functions by a state Exchange.

25. A draft slide presentation dated February 18, 2013, titled "High Level HIX Business and Technical Architecture Diagrams with Gaps, Issues, and Risks Annotated" for the Maryland Exchange indicates that in February 2013 significant portions of the website were at significant risk for delay. At what point did state officials know that the project was at risk? How was this communicated to CMS?

The project's risks were tracked through independent validation and verification activities conducted by BerryDunn. These reports were shared with CMS. A description of early red flags in these reports and the State's response can be found in the January 14, 2014 testimony to the Maryland General Assembly (Attachment 2).

26. On September 26, 2013, Charles Leadbetter, an official at Berry Dunn, a contractor tasked with providing independent verification and validation for the Maryland exchange, wrote Rebecca Pearce, then executive director for the Maryland exchange. Mr. Leadbetter was concerned about the exchange's plan to go live with the account creation, enrollment, and plan selection functions active. Mr. Leadbetter recommended the exchange "consider ways to reduce the scope of the October 1 go-live to the minimum amount of functionality possible." Why was Mr. Leadbetter's recommendation ignored?

His recommendation was reviewed and responded to contemporaneously by the executive director of the Maryland Health Benefit Exchange. This response letter is attached (Attachment 6).

27. In the letter, Mr. Leadbetter also raised concerns regarding the exchange's readiness. For example he wrote, "[a]though a third party company reviewed the systems environment from a hardware and intrusion security perspective, we do not have evidence that the application and data level security features were adequately tested and been properly configured for live operation." Prior to October 1, 2013, has the exchange conducted a complete end-to-end of the Maryland exchange systems?

The Maryland Health Benefit Exchange conducted a comprehensive security review prior to October 1, 2013.

a. How did the exchange define the boundaries for "end-to-end?

The system design and infrastructure dictate the boundaries of the application, and therefore dictate the boundaries of testing. The four criteria for boundary determinations are: defining the system type and security requirements; establishing the physical boundaries; determining the logical boundaries; and lastly, documenting the system interconnections and rationales behind

those interconnections. The Maryland Health Benefit Exchange then based its end-to-end assessment on the four criteria for boundary determinations.

b. What additional steps has the exchange taken to ensure that private information is protected?

The Maryland Health Benefit Exchange complies with the Minimum Acceptable Risk Standards for Exchanges (MARS-E) requirement to meet NIST SP 800-53 standards for moderate security systems, and also employs NIST SP 800-53 standards for high security systems. This results in a deeper and broader security control framework than is required by MARS-E.

The most sensitive data (personally identifiable information, personal health information, and federal tax information) are stored inside databases, which are encrypted by an industry standard purchased product. This provides encryption "at rest" meaning at all times the databases are an encrypted status to prevent unauthorized access. At the data center, all systems data is protected by multiple layers of firewalls and is further encrypted within the databases themselves.

Ongoing maintenance and monitoring occurs routinely and weekly reports on the security status of the system is provided to the Maryland Health Benefit Exchange executive IT management. Security tools include account monitoring, file integrity monitoring/detection, anti-virus detection/protection, weekly vulnerability scans, security configuring scans, database encryption and monitoring, trap monitoring, intrusion prevention/detection, and log management systems.

Finally, since IT security is a high priority, there are vendor security engineers available 24x7x365 to respond to any abnormalities or emergencies. There are also weekly security meetings between the Maryland Health Benefit Exchange and vendor security teams and the Maryland Health Benefit Exchange maintains an ongoing dialogue with HHS, IRS, the Maryland Cyber Security Office, and all third party vendors.

28. Mr. Leadbetter also raises concerns that "the application functionality that will be made operational, to our knowledge, has not been fully tested in a production-like environment. Mr. Leadbetter also raised concerns that CMS had raised the bar too low, and as a result "might be providing MD HBE [health benefits exchange] with false perceptions that the systems have been fully tested...." Given these concerns, what steps did the exchange take prior to October 1, to ensure that the functionalities that went live functioned as expected?

The Maryland Health Benefit Exchange's contemporaneous perspective prior to October 1, 2013 is best captured by the response of the executive director to Mr. Leadbetter's letter (Attachment 6).

Response from Ms. Yang
Executive Director
Massachusetts Health Insurance Exchange

Questions from Chairman Jordan
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
and from Chairman Lankford
Subcommittee on Energy Policy, Health Care and Entitlements

Joint hearing on:
"Examining ObamaCare's Problem-Filled State Exchanges"

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1. To date, how much money has the state received in establishment grants to set up a health insurance exchange?
   Massachusetts has received approval for $174 million in federal funds to set up the Health Insurance Exchange and related systems. Of this, $37.4 million is from establishment grants.

   a. Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?
      The Commonwealth received a $44.5 million Early Innovator grant and $92.1 million in Advance Planning Document Update (APDU) funds.

   b. How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?
      $64,222,811 through April 30. This represents an additional $7 million from the end of March on account of payments to vendors other CGI, which includes other project consultants and additional costs such as leases, office space, software licenses and other expenses.

   c. How much has the exchange obligated to spend, but has not yet been spent on exchange development?
      $70,733,717 through April 30.

   d. Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?
      Since late 2013, the Commonwealth has been working to stabilize its Exchange, enter a backlog of paper applications, and implement and operate its contingency plan. Additionally, the Commonwealth is assessing technology options to ensure it has a functioning Exchange for Open Enrollment 2015 (which starts in November 2014). Contract personnel have been brought on board to support all these activities and federal funding in the amount of $51 million has been requested.

2. Please provide the list of all contracts awarded to develop the exchange and its related systems, including the following information for each contract:

   a. When was the contract awarded?

b. What was the ceiling value of the contract and how much did the vendors receive to date?

c. Was the contract competitively bid or sole sourced?

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

e. Who is the responsible official for overseeing the contract?

f. How many contract modifications were made from the start of the contract?

This chart provides details regarding HIX-IES vendors for the information requested:

#	Vendor / Services	Date Awarded	Contract Amount	Amount Received to Date (thru 4/30/2014)	Competitively Bid or Sole-Sourced	Type	Overseer	Modifications
1	CGI – System Integration vendor	7/9/2012	$69,098,024	$17,278,988	Competitive	Fixed Price, Milestone-based	ITD since March 2014 UMMS from July 2012 to March 2014	6 amendments, the last 2 of which were for settlement negotiations
2	BerryDunn – IV&V vendor	10/9/2012	$10,147,895	$8,380,393	Competitive	Fixed Price	University of Mass Medical School (UMMS)	1 amendment
3	BrickLogix – 3rd party security tester	8/21/2013	$69,900	$69,900	Competitive	Fixed Price	UMMS	3 amendments
4	Interactive Accessibility – 3rd party accessibility tester	8/21/2013	$302,200	$54,598	Competitively bid, but no vendors responded. Then sole-sourced to known vendor.	Fixed Price	UMMS	0 amendments

Notes: The CGI engagement includes a series of change orders that total an additional $20 million. Federal guidelines require that states engage the services of an independent verification and validation vendor.

Under the contract terms and conditions, who is financially responsible for fixing problems with the system?
The current CGI contract requires CGI to stabilize, fix, and provide warranty for the system.

3. Does the exchange plan to continue with the current contractors or terminate and replace with more capable vendors? If the exchange decides to award new contracts, will all new contracts be awarded through competitive bids?
After an evaluation of our current HIX website, on March 17 the Commonwealth announced its decision to part ways with CGI based on the vendor's past underperformance and the future needs of the project. The Commonwealth is currently negotiating a careful transition agreement that protects and advances the project and timeline for a functional HIX by the Fall 2014 Open Enrollment.

In February, Sarah Iselin joined the Commonwealth's team as Special Advisor to the Governor for Project Delivery, providing a single source of decision-making and accountability, and the Commonwealth engaged the technology firm Optum to help turn the HIX project around, as Optum did for the federal Exchange. A key component to the smooth and thoughtful hand-off from CGI involves a systems and knowledge transfer to Optum. The Health Connector, which is an independent state agency, currently holds the contract with Optum/QSSI and has been negotiating costs over 30-day increments. Optum's services were procured on an emergency basis consistent with Health Connector procurement policy.

The Commonwealth will follow all relevant procurement laws for future contracts related to the HIX-IES project.

4. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?
The Commonwealth has modified three contracts since September 1, 2013. The CGI system integration contract has been modified to reflect the changing dynamic with CGI and the company's careful and thoughtful transition out of its current role. The modifications memorialize the ongoing negotiation period and note that there may be priorities the Commonwealth wants CGI to work on. Those priorities may differ from CGI's current contractual obligations, and both parties agree that CGI will not be in breach of contract by working on them. The modifications establish a timeframe for the negotiations, document that the negotiation period directives may change, and they change CGI's payment structure from milestone-based to time-and-materials based.

Additionally, the Independent Verification and Validation contract with BerryDunn was modified to extend the timeframe for provision of testing support services; extend key personnel given shift to multiple releases (from a single October 1, 2013 release); and adds a supplementary System Audit Review given additional releases. Also, the third-party security contract with BrickLogix was modified to add additional services for penetration testing, vulnerability scanning, and QualysGuard Web Application Scanning. Two additional modifications since were to extend the timeframe under which services could be delivered.

5. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

On May 5, the Commonwealth announced a dual-path plan to stand up a functioning HIX in time for the fall open enrollment. This dual-path plan includes either employing an off-the-shelf solution from hCentive that has been successful in other states or connecting Massachusetts to the Federally Facilitated Marketplace for the Fall. This responsible plan will help ensure Massachusetts residents have a website that will provide access to the benefits created through the Affordable Care Act. At this junction, the Commonwealth is refining costs relative to the dual-track solutions. It is also premature to indicate costs relative to original cost estimates considering the ongoing negotiations with the former systems integrator, CGI.

6. To date, how much has the state or the exchange spent on advertisements publicizing the law and/or the exchange? Did the state or the exchange use federal or state funds?
The Health Connector has, to date, spent $3.9 million on advertising placement, production and other related costs. Advertising has been supported completely by federal grant funding. In Massachusetts, with an existing Exchange in place, advertising plays a vital role in educating residents about the new choice, benefits and expanded subsidy opportunities created by the Affordable Care Act.

7. After September 31, 2013, approximately how much has been paid in bonuses to exchange employees?
Nothing.

8. What are the estimated operational costs for the exchange in the years 2014, 2015, and 2016?
The estimated range of Exchange operational costs, excluding expenses incurred for one-time ACA transition activities, is between $40.6 million and $45.1 million for 2014, $37.8 million to $42.2 million in 2015, and $39.4 and $44 million in 2016. By way of comparison, the Fiscal Year 2012 budget for the Health Connector was $35 million. These project figures going forward are estimates, have not been approved by the Board of Directors, and are highly influenced by enrollment projections. As such, longer-term costs are subject to change.

    a. What revenue sources will the state utilize to finance the exchange in these years? What is the expected revenue?
    As in the past, the Health Connector envisions utilizing carrier fees supplemented by state appropriations to fund operating costs. These are the revenue sources (along with federal dollars) that have funded the Connector to date. Carrier fees are agreed by contract between the Health Connector and individual carriers offering products through its exchange on an annual basis. In addition to carrier fees, the Health Connector is funded by a mixture of state general funds and dedicated revenues, such as an excise tax on cigarettes sold in Massachusetts.

    b. How will the state address any deficits in the exchange's budget?

When the Health Connector was established in 2006, it was appropriated $25 million to cover start-up costs. In the event that the Exchange incurs deficits in 2015, available reserves currently estimated at $23 million will be utilized.

c. Will the state seek any federal money to help finance the exchange's operations?
Consistent with relevant federal funding guidance, the Health Connector has applied for and received Level 2 Exchange Establishment grant funding to support its 2014 operations.

9. Who was the state's primary point of contact at CMS?
Amanda Cowley, who served as the Director of the State Exchanges Group at the U.S. Department of Health and Human Services, was the Commonwealth's main point of contact.

a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? What was the role?
CMS reviewed project scope, work plans and schedules, and the approach to executing the work plans and schedules both as part of the process to review grant and APDU requests and to oversee the development of the system and implementation of the program. Additionally, through various Gate Reviews/Establishment Reviews, CMS performed extensive reviews of the management of the project, the requirements and design of the system, the functioning/quality of the system, and the Commonwealth's contingency plans to ensure those with insurance maintained coverage, and those seeking health care coverage for the first time get coverage.

b. How did the state ensure the exchange IT build would be completed on schedule?
The Commonwealth took several actions to have a functioning HIX/IES on October 1, 2013, including:
- **Deferring implementation of non-critical scope after October 1, 2013 and triggering operational or functional contingency plans as needed;**
- **Eliminating some non-critical scope from the project altogether or transitioning it entirely to other vendors;**
- **Actively pressing for and reviewing CGI's project status metrics to monitor progress;**
- **Actively pressing for CGI to bring on more and more skilled resources;**
- **Assuming control of some components of CGI's work that were particularly of low quality or effectiveness;**
- **Augmenting CGI's testing resources with Commonwealth Subject Matter Experts (SMEs);**
- **Issuing a request for a Corrective Action Plan to CGI in order to "get to green" on the project schedule; and**
- **Developing gates in the end-to-end process so that only those business functions which passed testing criteria were allowed to go live.**

- **Additionally, the Commonwealth developed workarounds to ensure residents maintained existing coverage or received coverage for the first time.**

10. Did the state conduct independent assessments on exchange readiness?
Yes.

    a. Who conducted the reports and when where they issued?
    BerryDunn completed weekly and monthly Independent Verification and Validation reports.

    b. Who were the recipients of these readiness reports?
    The HIX-IES project Senior Management Team, which includes officials from the Commonwealth's involved agencies, the University of Massachusetts Medical School, the Health Connector, and MassHealth, received the reports.

11. When did the state first learn that the exchange build was behind schedule?
The Commonwealth began dictating scope deferral and reduction in February 2013, frequently adjusting the schedule in an effort to free up capacity for the vendor team to focus on critical functions and processes. This de-scoping was designed to have a HIX with core working functions in place on October 1. After October 1, as system use increased, the depth of the deficiencies in the system became apparent.

    a. When did you first realize that your website would not be operational on October 1st?
    The website launched on October 1 included an end-to-end experience for applicants seeking unsubsidized coverage, and the ability for those seeking subsidy to complete an application online. The deficiencies in that functionality for users were not fully realized until early November as system usage increased and user-experience issues were identified and not able to be fixed by CGI, with no further functionality or system improvements delivered.

    b. When did you inform the federal government of your exchange's problems? Who did you inform?
    Throughout the system development and testing processing, the Commonwealth stayed in close, regular contact with CMS, including providing regular reports on project scope and status, and completing CMS' operational review process. The state Exchange support team led by Amanda Cowley was the Commonwealth's chief contact at CMS.

12. Who was the central individual responsible for the exchange's development?
The Commonwealth's project management structure was based on oversight from three entities, the University of Massachusetts Medical School, the Health Connector, and MassHealth. In February 2014, Governor Patrick appointed Sarah

Iselin as Special Advisor to the Governor for Project Delivery, providing a single source of decision-making and accountability.

a. Who decided whether to authorize the exchange to launch on October 1st?
The project's Steering Committee, made up of representatives from each oversight agency, made decisions regarding the scope of the system launch on October 1. The Senior Management Team included directors, CIOs and other officials from UMass-Medical School, the Health Connector, and MassHealth.

b. What was the date in which day one specifications were finalized?
The Commonwealth made the first decisions to de-scope in February 2013, and consistently provided updates to the Health Connector Board of Directors. These updates includes progress reports and discussion of the system status at monthly board meetings throughout 2013 including a detailed update on expected functionality in the first phase of the system at the September 12, 2013 meeting.

c. Who made the final decision what features would launch on October 1st?
The project's Steering Committee.

13. To date, what has the state done to identify the causes of the exchange's failure on October 1st? To date, who has been held accountable for the failures experienced on October 1st? How were they held accountable?
As a result of an underperforming IT vendor, CGI, the Commonwealth experienced significant challenges that impeded its ability to achieve the full vision for the HIX website by October 1, 2013. After conducting a top-to-bottom review of the current status of the HIX website, in mid-March the Commonwealth decided to part ways with CGI. Based on CGI's past underperformance and the future project needs, the Commonwealth determined it is in its best interest to secure a careful transition agreement, and the Commonwealth is in the midst of negotiating an agreement that protects and advances the project and the timeline for a functional HIX by the next Open Enrollment.

The Massachusetts Health Connector also requested two external reviews of the HIX project by the MITRE Corporation and Microsoft. Both reports noted project management flaws that Governor Patrick swiftly addressed in February 2014 by moving to a management structure with one single point of authority. Sarah Iselin, a health care leader with public and private sector experience, was named Special Assistant to the Governor for Project Delivery, with officials from the Connector, MassHealth and new IT consultant Optum reporting to her on a daily basis. Additionally, the contract with CGI was assigned from UMMS to the Commonwealth's Information Technology Division in March 2013.

14. To date, how many people enrolled in private plans on your state exchange?
As of April 29, 35,872 people had enrolled in a Qualified Health Plan or a Qualified Dental Plan through the Health Connector. Additionally, 112,000 people are in extended Commonwealth Care coverage, as legacy Commonwealth Care members

or people who moved into that coverage from the state Medical Security Plan, which ended on December 31, 2013.

15. To date, how many of those enrollees have paid their first months' premium?
The Massachusetts Health Connector does not effectuate an enrollment with a carrier until the first premium has been paid. All enrollees into a QHP or QDP have paid their first month's premium.

16. To date, how many of those enrollees had previously been insured?
Of the approximately 36,000 people who have enrolled in a Qualified Health Plan or Qualified Dental Plan, about 20,000 of those people were previously insured through health plans purchased through the Health Connector and were renewing with the Health Connector; it is unknown how many of the remainder were previously insured.

17. How many individuals were hired to process paper applications because the website did not work? How much did this cost? Was it paid for by federal or state funds?
The Commonwealth engaged technology firm Optum to support a variety of tasks to turn the HIX project around, including elimination of the paper application backlog from a high of 72,000 to zero within two months. Approximately 300 Optum staff data entered paper applications.

18. What percentage of the originally planned features of the system was expected to be functional on October 1st?
After removing a number of pieces of functionality from the October 1 launch, including program determination and enrollment functions, the Commonwealth estimates less than 25 percent of the original features were part of the initial rollout on October 1.

    a. What percentage of the originally planned features of the system was actually functional on October 1st?
    It is difficult to determine a particular feature's size in the overall system, but the Commonwealth estimates less than a quarter of the originally-planned features were available on October 1 based on the initial proposed scope in July 2012.

    b. What percentage of the originally planned features of the system is functioning currently?
    We have not added any significant features to the system since October 1. Instead, the Commonwealth instituted a multitude of manual workarounds, or has moved work (e.g. 834, small group) out of the HIX and to other vendors. In recent months, system stability has improved for users, although no new functionality has been added.

    c. What functions remain to be built?
    Remaining functions to be built include Individual Eligibility (subsidized), Subsidized Shopping, SHOP, Broker Portal, Shared Portal Functions

(Message Center, Chat, Mobile), Full Customer Service Functionality (only basic functions (e.g. search) are currently available), Assister/Navigator Portal, Administrator Portal, Full Noticing functionality, Automated Reporting, Online Appeals Submission, Appeals Management, Full Decision Support (cost calculator) and Account Management/Report A Change.

19. Prior to October 1, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped? How was the public made aware of these changes?
The Commonwealth began dictating scope deferral and reduction in February 2013, frequently adjusting the schedule in an effort to free up capacity for the vendor team to focus on critical functions and processes. A number of significant functions have been delayed or removed from CGI's scope. Most significantly, program and eligibility determination functions remain pending. Important functions that were removed from CGI's scope include the small-group shopping platform, which operated online through another vendor, and enrollment transaction (834) functions that were also removed from CGI. Additionally, the sale of Qualified Dental Plans was moved from online sales to a call center solution.

Other features that remain pending are plan shopping and online enrollment for subsidized users; some plan and provider search functions; and designated portals for Navigators and brokers. The Health Connector updated the Board of Directors on the status of the project in public meetings throughout 2013, and in September 2013 the agencies supporting the HIX project participated in a media roundtable that outlined what functionality would be in place on October 1.

20. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)
In February 2014, Governor Patrick brought in Sarah Iselin as Special Assistant to the Governor for Project Delivery, to serve as a single point of authority and accountability for the management of the HIX project. Special Assistant Iselin previously served as the Commissioner of the Massachusetts Division of Health Care Finance and Policy and is currently on leave from her role as Senior Vice President of Strategy, Policy and Community Partnerships and the Chief Strategy Office of the Blue Cross Blue Shield ("BCBS") of Massachusetts.

Special Assistant Iselin is the sole state executive responsible for project management reporting directly to the Governor, and is supported by an HIX project executive committee, including Chief Information Officer for the Commonwealth, Bill Oates, and IT consultant Optum. These combined resources provide technical expertise to the Commonwealth for the HIX project.

21. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?
No.

22. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?
Throughout 2013, the Commonwealth took a number of steps to improve the vendor's performance. The Commonwealth implemented daily pace reports, tracking development and testing of every piece of the project. The vendor was mandated to reorganize members of its team to focus exclusively on key areas, and was also directed to engage additional staff with specialized skillsets (as part of this process, the Commonwealth prioritized critical functions so that development and testing focused on those necessary areas).

Faced with continued underperformance by CGI, the Commonwealth executed a series of program management levers to hold CGI accountable to the scope of work and project schedule, including a Corrective Action Plan required of CGI in July 2013, an Informal Dispute Resolution process initiated in October 2013 and contingency plans created when it was clear the software schedule was behind. Additionally, the Commonwealth took over key aspects of the project, in whole or in part, including managing weekly management team meetings and producing weekly information reports, managing the change control process to prioritize and schedule software changes, managing project risks and issues, and planning and coordinating functional software testing.

23. According to the *Boston Globe*, your exchange has temporarily placed approximately 125,000 residents who have applied for financial assistance through the exchange onto Medicaid temporarily. Why did the state do this?
Our number one goal is to protect and expand health care coverage even as we face IT challenges. Transitional Medicaid coverage represents a critical and alternative pathway to coverage while we seek to turn the HIX project around.

Working in concert with the federal Centers for Medicare and Medicaid Services (CMS), MassHealth stepped in to create our current transitional coverage solution for residents who applied for assistance with health coverage but whose applications have not yet been able to be processed. On March 31, MassHealth extended this Transitional Coverage program, with the permission of CMS, through June 30, 2014. As of April 9, approximately 190,000 individuals had been enrolled. As we continue to work toward a long-term solution that moves these individuals into their final ACA-compliant coverage, these individuals can visit the doctor, get needed prescriptions and know that they are covered in the event of a serious illness or accident.

    a. Did the federal government authorize this? If so, did CMS explain to you the legal basis by which Massachusetts was allowed to offer transitional Medicaid coverage for these residents?
    Yes, the Administration worked closely with CMS to seek approval for our Transitional Coverage program. The Administration has been in regular contact with CMS through phone calls and in-person meetings in

Washington, DC, during this period. The CMS authority for the Transitional Coverage program is through MassHealth's Section 1115 Demonstration.

b. Was this expense approved by the Massachusetts legislature?
Based on reasonably conservative assumptions about enrollment and other factors that determine costs, we currently believe that this Transitional Coverage program can be supported by MassHealth in fiscal year 2014 without supplemental appropriation. As a result, while keeping them closely informed, we did not need to seek additional appropriations from the Massachusetts legislature.

c. What is the estimated state and federal cost for the roughly 125,000 individuals placed on to the Medicaid program?
The federal government has agreed to reimburse MassHealth for payments for care for those up to 400% of the federal poverty level, with federal financial participation (FFP) reimbursement ranging from 50% to 75% depending on eventual program placement. As of April 9th, MassHealth has paid $24 million in claims for transitional coverage on a gross basis. We will continue to refine these estimates as we secure additional information about enrollment, per-member costs, and the income distribution of members.

d. Is it possible that some of those placed on Medicaid because the state couldn't determine their eligibility will ultimately not be eligible for either Medicaid or Exchange subsidies? Why or why not?
While this is possible, we believe it to be a very small portion of those who currently have transitional coverage. Those moved into the transitional coverage had self-identified as newly seeking subsidized coverage, and we know that most of the remaining uninsured in Massachusetts are low-income. Those that did not self-identify in this way purchased unsubsidized coverage. MassHealth, the Health Connector, and Optum are currently working to identify anyone with an income above 400% of the FPL – making them ineligible for MassHealth or Health Connector subsidies – to move them out of transitional coverage.

e. Ms. Yang testified before the Committee that the exchange had eliminated the backlog of applications. How many applicants in this backlog ultimately were placed into this transitional Medicaid program?
As of March 27, Massachusetts successfully eliminated our application backlog, which at its peak was up to 72,000 applications. When those applications were processed, it was determined that some of the individuals included on these applications already had subsidized coverage through MassHealth or the Health Connector (in the Commonwealth Care program), and nearly all of the remainder were placed into transitional coverage as a result of challenges with performing a full program determination in the system. We have since kept pace processing new applications, averaging around 1,400 paper applications per day. As a result, we have been able to enroll people into transitional coverage on a daily basis so that most

applicants no longer have to wait long periods of time not knowing whether coverage is available to them.

24. A review of the Massachusetts exchange conducted by MITRE found "no single entity within the Commonwealth owns IT governance and there are no clearly identified roles, responsibilities, decision-making authorities, and accountabilities." When did Massachusetts become aware that the project lacked "clearly identified roles, responsibilities, decision-making authorities, and accountabilities? What did the state do to correct this problem?
To improve project management structure, in February 2014 Sarah Iselin was named Special Assistant to the Governor for Project Delivery to oversee the HIX project, bringing a clear, strong voice to the project and the decision-making process. Additionally, Optum was brought on as an IT advisor, and the contract with CGI was assigned from UMMS to ITD. This change in structure has improved system stability, eliminated the backlog of paper applications, and helped put the project on a positive track for the fall Open Enrollment period.

25. MITRE also found "[t]he requirements development process took more time than was reasonable." When did the state become aware of concerns that the requirements were delayed?
The Commonwealth became concerned with the pace of requirements development almost immediately. The Commonwealth attributed the initial delays to the vendor allocating inadequate quality resources to gathering business requirements, a project organization that was overly complex and requiring significant ramp-up time for vendor staff to be effective, and the vendor's unwillingness to re-conceptualize project organization (including timeline and delivery plan).

    a. Were any of these delays with developing requirements attributable to delays by CMS in issuing guidance?
    No.

    b. How did the state attempt to address these concerns?
    In order to mitigate these delays and try to get requirements back on track, between September and November of 2012, the Commonwealth requested that CGI replace its Project Manager (who lacked the necessary experience to manage a project of this complexity) and its Contract Manager. CGI removed those managers, replacing them with Jeff Bailey as Project Manager and Sasi Naydu as Contract Manager, who remain in those roles. In addition, the UMass-Medical PMO, on behalf of the Commonwealth, requested multiple times during the course of the project for CGI to add more quality resources.

26. MITRE found that "Problems with eligibility determination were identified but not raised during the development life cycle." When did exchange officials first become aware of problems with the eligibility determination system?

    a. When did the state become aware of these problems?

The Commonwealth became aware of the issues with the eligibility system in the first quarter of 2013. The Commonwealth clearly identified this functionality as a top priority and took steps to reinforce with the vendor the importance of this piece of this system, and immediately developed contingency plans for basic eligibility determinations in the event functionality was not available or not adequately tested. In August 2013, the Commonwealth deferred this functionality to after October 1 because it was not ready for launch.

b. What was done to correct the problems?
Despite the Commonwealth's clearly expressed need for this important functionality, the date for adding this functionality was moved a number of times by the vendor – from late October to mid-November to early December – before it was set aside. Testing on eligibility and subsidy determination continues.

27. The MITRE report stated that "There does not appear to be a consistent, unified vision for the system nor clear lines of accountability for implementing the vision. A number of organizations are involved with different priorities for the system." When did the exchange officials first become aware of concerns that there was not a "consistent, unified vision for the system nor clear lines of accountability for implementing the vision?" What was done to resolve these concerns?
The Commonwealth has been committed to creating a system that allows residents full access to the choice, benefits and expanded subsidies created by the Affordable Care Act. By adjusting its project management structure and bringing in Sarah Iselin, the Commonwealth has a clear, strong decision-making voice leading the project.

28. What are the next steps in fixing the numerous problems identified with the exchange?
After a comprehensive review of the system, the Commonwealth has decided to pursue a dual-track strategy that will include both a successful off-the-shelf solution and the Federally Facilitated Marketplace. This strategy aims to ensure the Commonwealth continues to expand access to affordable, quality health insurance through the ACA. The off-the-shelf solution is from hCentive, which has powered Exchanges in Colorado, Kentucky and elsewhere. This plan calls for concurrent implementation of the two platforms, and ensures the programs that make Massachusetts a national leader in health care access, affordability and choice remain intact. This includes the State Wrap program, which through additional state premium assistance helps makes health insurance more affordable for tens of thousands of residents. The plan also seeks new carrier accommodations to reduce the business and operational burdens associated with migrating to an external Exchange.

29. Does the exchange have any plans to revert to the federal system or implement another state's system? If so, how was that decision made?

The Commonwealth and Optum have been carefully assessing two long-term options to have a functional HIX for the fall, and the Commonwealth is pursuing a dual-track strategy that includes both the federal system and an off-the-shelf platform used by Colorado, Kentucky and other states. This decision, which was announced on Monday, May 5, is the next step after the Commonwealth and Optum reviewed the existing system and discussed options with CMS and other state leaders who have successfully implemented a Health Insurance Exchange.

April 30, 2014

Response from Mr. Lee
Executive Director
Covered California

Questions from Chairman Jordan
Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
and from Chairman Lankford
Subcommittee on Energy Policy, Health Care and Entitlements

Joint hearing on:
"Examining ObamaCare's Problem-Filled State Exchanges"

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1. To date, how much money has the state received in establishment grants to set up a health insurance exchange?

   $1,065,683,056

   a. Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?

      In addition to the establishment grants, federal money via cost sharing arrangements for IT related expenditures was received by the state.

   b. How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?

      The total spent on the development of the Exchange through March 2014 is $406,042,688. Of this, $172,553,070 was spent on the development of related IT systems.

   c. How much has the exchange obligated to spend, but has not yet been spent on exchange development?

      The state has obligated $212,117,351 in Fiscal Year 2013-14 and will spend the remainder of the grant funds in Fiscal Year 2014-15.

   d. Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?

      No.

2. Please provide the list of all contracts awarded to develop the exchange and its related systems, including the following information for each contract:

Given the limited time constraints, attached is a spreadsheet with information on all contracts awarded related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) Project.

a. When was the contract awarded?

   Please see contract award date column in attachment.

b. What was the ceiling value of the contract and how much did the vendors receive to date?

   Please see amount column in attachment.

c. Was the contract competitively bid or sole sourced?

   Please see procurement column in attachment.

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

   Please see contract type column in attachment.

e. Who is the responsible official for overseeing the contract?

   See attached. This is provided in the Contract Manager column. The program area responsible for overseeing the contract has been provided. We are happy to provide more detailed information if desired.

f. How many contract modifications were made from the start of the contract?

   Please see number of contract modifications column in attachment.

g. Under the contract terms and conditions, who is financially responsible for fixing problems with the system?

   The System Integrator (Accenture) is financially responsible for fixing any system defects in the scope of the contract associated with CalHEERS. This includes any software, hardware, network, service, or hosting solution provided by Accenture, or by any contracted third-party authorized to provide services under Accenture's performance of the contract.

3. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?

   Accenture, Amendment #3: Executed November 26, 2013: (1) Added funds ($6M) for System Change Hours ($2.5M) and Postage-related charges ($3.5M) (2) Updated miscellaneous contract language, definitions, and Exhibits.

Accenture, Amendment #4: Executed March 25, 2014: Changed deadline for the State to choose the option for Core Enhancement Functionality of the Expanded System to August 31, 2014.

Eclipse, Amendment #1: Executed March 18, 2014 - Extended end term from March 18, 2018 to June 30, 2014 to complete unanticipated tasks as part of the Agreement.

Kearnford Application Systems Design (KASD), Amendment #1: Executed September 13, 2013 - Added funds ($278,720) and additional resources (three (3) QA Specialists and eight (8) Testing Specialists) to Agreement.

Kearnford Application Systems Design (KASD), Amendment #2: Executed December 10, 2013 - (1) Extended end term from December 31, 2013 to July 31, 2014 (2) Corrected supplier name.

4. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

Covered California is not requesting additional funds to address any items within the original scope of the CalHEERS project. Accenture is financially responsible for fixing any system defects associated with CalHEERS. This includes any software, hardware, network, service, or hosting solution provided by Accenture, or by any contracted third-party authorized to provide services under Accenture's performance of the contract. Additional federal and state legislation, guidance, and policy defined after design was completed in the summer of 2013, has and will continue to be the subject of changes to the exchange system, and will require additional funding to complete.

5. To date, how much has the state or the exchange spent on advertisements publicizing the law and/or the exchange? Did the state or the exchange use federal or state funds?

The total marketing/advertising spend from July 2013 through March 2014 is as follows:

Marketing Research:	$1.4M
Advertising Media Placements:	$49.5M
Ad production & Collateral Development & Fees:	$17.4M
TOTAL:	$68.3M

This came from Federal Funding.

6. After September 31, 2013, approximately how much has been paid in bonuses to exchange employees?

The State of California has not paid its employees bonuses.

7. What are the estimated operational costs for the exchange in the years 2014, 2015, and 2016?

   FY 2013-14 = $443,844,000
   FY 2014-15 = $378,446,000
   FY 2015-16 = $310,714,000

   a. What revenue sources will the state utilize to finance the exchange in these years? What is the expected revenue?

      Revenue sources include per member per month assessments on premiums, grant funds, and non-grant cost share (general and federal funds) for IT related costs for FY 2013-14 and FY 2014-15. For FY 2015-16, revenue sources include per member per month assessments on premiums, and non-grant cost share for IT related costs.

   b. How will the state address any deficits in the exchange's budget?

      By reducing expenditures and/or increasing revenues.

   c. Will the state seek any federal money to help finance the exchange's operations?

      Notwithstanding federal money via cost sharing arrangements for IT related expenditures that the state will continue to receive, California does not intend to seek any additional federal money to fund the exchange's operations.

8. Who was the state's primary point of contact at CMS?

   Amanda Cowley, Director, State Exchanges Group, HHS/CMS/CCIIO

   a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? What was the role?

      Yes. The Center for Consumer Information and Insurance Oversight (CCIIO) within CMS provides regular oversight in California's use of federal funds. CCIIO requires states to provide detailed narratives, work plans and budgets when requesting grant funds. When grants are awarded, CCIIO issues terms and conditions for grant spending that includes additional restrictions on specified funds. The release of these funds is pending approval of additional detailed expenditure plans and/or the completion of mutually agreed upon milestones. CCIIO also requires the regular reporting on grant activities, sub-grantee and vendor contract awards and grant expenditures. Changes to pre-approved grant budgets or scope of work require CCIIO's prior approval.

   b. How did the state ensure the exchange IT build would be completed on schedule?

The CalHEERS Project had a strong Governance structure which included an Executive Steering Committee (ESC), comprised of the 2 Project Sponsors as voting members: Covered California and the California Department of Health Care Services; with stakeholder partners participating to guide and provide input. The ESC meets regularly to make decisions that guide the project. The Office of Systems Integration (OSI) manages the contract for the prime vendor. Any changes to the Project are strictly controlled by the Change Control Board, which governs the scope and requirements traceability for the Project as a whole. An Independent Verification and Validation (IV&V) vendor monitors the Project and reports monthly and as needed to the 2 Sponsors.

9. Did the state conduct independent assessments on exchange readiness?

   Covered California conducted regular system testing and internal readiness assessments. The System Integrator following a rigorous protocol to perform readiness assessments for all functionality of the exchange system, with participation by the State and the Independent Validation and Verification vendor.

10. Who was the central individual responsible for the exchange's development?

    Given the limited time constraints, the following answers are specific to the CalHEERS Project. The CalHEERS Project is governed by an Executive Steering Committee co-chaired by Peter V. Lee, Executive Director at Covered California, and Toby Douglas, Director of the California Department of Health Care Services.

    a. Who decided whether to authorize the exchange to launch on October 1st?

       The Executive Steering Committee.

    b. What was the date in which day one specifications were finalized?

       June 21, 2013

    c. Who made the final decision what features would launch on October 1st?

       The Executive Steering Committee.

11. To date, how many people enrolled in private plans on your state exchange?

    As of April 15, 2014 1,395,929 individuals have enrolled in qualified health plans through Covered California.

12. To date, how many of those enrollees have paid their first months' premium?

    Covered California enrollees pay their premiums directly to their selected health plans. Covered California is working closely with its health plans to ensure adherence to payment policies and appropriate claiming of federal advanced premium tax credits and

cost sharing reductions. Data from our health plan shows that approximately 85 percent of enrollees pay their first month's premium.

13. To date, how many of those enrollees had previously been insured?

    Covered California does not currently collect this information.

14. What percentage of the originally planned features of the system was expected to be functional on October 1st?

    California's original plan in June 2012 was to implement three separate releases. The first two releases, containing approximately 70% of the overall functionality, would be implemented by October 1. The original release dates and key features were as follows:

    - Release 1 – Portal (7/1/13)
        - Anonymous Screening
        - Shop & Compare Tools
        - Shop Employer Tools
        - Assister Registration and management
    - Release 2 – Enrollment (9/28/13)
        - Eligibility & Enrollment features
        - Premium Processing
        - Notices
        - Plan and Benefit Assistance
        - SHOP features

    a. What percentage of the originally planned features of the system was actually functional on October 1st?

        The following features were functioning as of October 1, 2013:
        - Anonymous Screening
        - Shop & Compare Tools
        - Assister Registration and management
        - Eligibility & Enrollment features
        - Notices
        - Plan and Benefit Assistance
        - Assister Registration and management

    b. What percentage of the originally planned features of the system is functioning currently?

        The following features are currently functioning:
        - Anonymous Screening
        - Shop & Compare Tools
        - Shop Employer Tools
        - Assister Registration and management
        - Eligibility & Enrollment features

- Notices
- Plan and Benefit Assistance
- SHOP features
- Assister Registration and management

c. What functions remain to be built?
Renewal Processing
Premium Processing
Additional Usability enhancements

15. Prior to October 1st, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped?

California changed its release plan from three releases to five to extend the overall implementation of all planned features. California did not descope features, it did reschedule features. Below is an outline of the original five release schedule:

- Release 1 – Assister Registration (8/19/13)
  - Assister Registration and management
- Release 2 – Enrollment (10/1/13)
  - Anonymous Screening
  - Shop & Compare Tools
  - Shop Employer Tools
  - Eligibility & Enrollment features
  - Premium Processing
  - Notices
  - Plan and Benefit Assistance
- Release 2.5 - Financial Management (11/18/13)
  - SHOP features
  - Financial Management
  - Plan Management
  - Reporting
  - Education and Outreach Support
- Release 3 – Program Integration (12/31/13)
  - Distributed Case Management and Interfaces with SAWS
- Release 4 – Expansion (March 2014)
  - Appeals
  - Additional Interfaces
  - Additional Notices
  - Reports
- Release 5 Operations Support (June 2014)
  - Renewals
  - Reports

a. How was the public made aware of these changes?

The Covered California Board of Directors meets monthly in a public forum. Information can be found at:
http://www.healthexchange.ca.gov/BoardMeetings/Pages/Default.aspx
Covered California also issues regular press releases. Those can be found at:
http://news.coveredca.com/

16. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)

Given the limited time constraints, the following information is specific to the CalHEERS Project.

Juli Baker, Chief Technology/Information Officer, Covered California

Dr. Baker has 30 years of experience in Information Technology (IT) systems development. She is PMP certified in project management. She directed the IT system development projects for several statewide child welfare systems, statewide eligibility and Medicaid and child support systems, operated systems for mental health and developmental disabilities, and implemented financial management systems. Dr. Baker was a senior executive in information systems and management consulting in the private sector prior to joining the Exchange. She participated in achieving Systems Engineering Institute (SEI) Capability Maturity Model level IV certification for her company's government sector practice. Prior to that, she held executive positions in Information Technology for the state of Colorado. She received her undergraduate degree at Wesleyan University in Connecticut, and Masters and PhD degrees at the University of Colorado.

Karen Ruiz, Project Director, CalHEERS

Ms. Ruiz currently serves as the Project Director for the CalHEERS system project which is a joint venture between Covered California and the Department of Health Care Services. Beginning on October 1, 2013, the CalHEERS system was used to successfully enroll more than 3 million Californians in new healthcare programs under the Affordable Care Act.

Ms. Ruiz previously served as the Project Director for CalPERS $500 million pension and health system consolidation and modernization project. The system, launched in September, 2011, replaced over 49 legacy systems and serves as the single solution managing pension and health benefits for over a million public employees.

Prior to her appointment at CalPERS, Ms. Ruiz served as the Deputy Director and Chief Information Officer for the Department of Social Services and also served as part of the

IT executive management team at the Employment Development Department, overseeing IT Governance, project management, and enterprise architecture.

Ms. Ruiz is a certified Project Management Professional and earned her bachelor's degree in Business Administration and Finance at California State University, Sacramento.

17. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?

No.

18. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?

No, there have not been concerns raised about the technical ability to build the system.

Response from Mr. Leitz

Interim Chief Executive Officer

Minnesota Health Insurance Exchange

Questions from Chairman Jordan

Subcommittee on Economic Growth, Job Creation and Regulatory Affairs

and from Chairman Lankford

Subcommittee on Energy Policy, Health Care and Entitlements

Joint hearing on:

"Examining ObamaCare's Problem-Filled State Exchanges"

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1. To date, how much money has the state received in establishment grants to set up a health insurance exchange?

   Minnesota has received approximately $155 million in federal establishment grants.

   a. Outside of federal exchange establishment grants, did your state receive any additional federal funds for the development of the exchange and related systems? If so, how much?

      Federal guidelines require that state based exchanges cost allocate expenses related to IT development to Medicaid. As such, Minnesota has cost allocated $64,650,000 to Medicaid pursuant to federal guidelines. $38,382,409 of Medicaid funds have been spent as of April 1, 2014.

   b. How many federal dollars were spent to date on the development of your state's exchange and its related IT systems?

      As of April 1, 2014, $68,009,518 in establishment grants has been spent. This figure does not include Medicaid spending.

   c. How much has the exchange obligated to spend, but has not yet been spent on exchange development?

As of April 1, 2014, $50,753,793 has been obligated. Of that, $38,746,780 is from establishment grant funds and $12,007,013 is from Medicaid.

d. Have exchange employees discussed requesting additional federal funds for the exchange? If so, how much and for what purpose?

MNsure leadership has had discussions regarding the ability to carry-over federal establishment grant funds that MNsure has already received for use beyond 2014. These funds would be earmarked for information technology infrastructure development and improvements.

2. Please provide the list of all contracts awarded to develop the exchange and its related systems, including the following information for each contract:

a. When was the contract awarded?

b. What was the ceiling value of the contract and how much did the vendors receive to date?

c. Was the contract competitively bid or sole sourced?

d. What was the type of contract, e.g., fixed-price, T&M, cost-reimbursement?

e. Who is the responsible official for overseeing the contract?

f. How many contract modifications were made from the start of the contract?

Please see answers to each question below.

Contractor: Maximus, Inc.

a. Fully executed July 14, 2012
b. Original Contract amount - $41,246,226
    a. Current Contract amount - $46,378,656
    b. Paid to date April 25, 2014 - $30,465,804
c. Competitive Bid
d. $1,757,760 – Time and material, Balance Fixed Price ($44,620,896)
e. April Todd-Malmlov or her successor
f. 5 amendments
    a. Amendment 1 – Added $660,000 for license to third party software (Curam)
    b. Amendment 2 - $1,973,471 project management
    c. Amendment 3 - $1,999,999 ($1.2 million T&M – balance fixed price project management)
    d. Amendment 4 $498,960 (T&M only)
    e. Amendment 5 – date extension

Contractor: Price Waterhouse Coopers

a. Master Contract with state established February 25, 2013. Mnsure work order under master contract fully executed March 4, 2013
b. Original Statement of Work amount - $801,054
    a. Current Statement of Work amount - $5,535,892
    b. Paid to date April 25, 2014 – $2,662,900
c. State Master Contract
d. Time and Material
e. MN.IT Central (state's centralized Information Technology agency, overseeing Identity Access Management activity).
f. 3 amendments
    i. Amendment 1 - $2,135,220
    ii. Amendment 2 – $1,699,946

Amendment 3 - $899,672

Under the contract terms and conditions, who is financially responsible for fixing problems with the system?

For each of the above contracts, there are deliverables for which vendors and sub vendors are accountable. The state intends to hold vendors accountable for their duties under these contracts.

3. Does the exchange plan to continue with the current contractors or terminate and replace with more capable vendors? If the exchange decides to award new contracts, will all new contracts be awarded through competitive bids?

In January 2014, MNsure commissioned Optum to perform an end-to-end review of MNsure's project management, IT system, and customer service functions. Optum recommended that MNsure put a lead vendor in place to provide overall project management of the IT system. After allowing for a competitive bid process consistent with MNsure's procurement policies, MNsure has since come to terms with Deloitte, who will serve as the lead vendor. One of the tasks assigned to Deloitte will be to assess the IT system within the context of the Optum recommendations, recommend how to proceed, and implement the final decision, responsibility for which ultimately lies with the State of Minnesota.

The process for letting and entering into contracts has been and will continue to be consistent with the procurement policies and laws that govern MNsure.

4. Did the state or the exchange issue any contract modifications after September 1, 2013? If so, what was the reason for these modifications?

Yes. Maximus Amendment #4, Amendment #5, and Exhibit C 1/8/14, all which are attached for your review. While Amendment #4 and Amendment #5 to the Maximus contract are clear on their face, Exhibit C outlines payment milestones for deliverables

under the Maximus contract. The amendment reflects a staged IT release schedule with timeliness penalties more clearly defined.

5. In total, how many additional funds will be needed to fix problems with the exchange and its related systems? If you combine these with the money already paid under those contracts, how does that compare with your original government cost estimate?

   MNsure does not expect to require additional funds for IT improvements. Instead, MNsure will rely on reallocating existing establishment grant funds and seek authority to carry forward existing grant funds. However, we are working with Deloitte to perform a system assessment. In the event that the assessment would identify a need for additional resources, MNsure would seek funds consistent with federal requirements.

6. To date, how much has the state or the exchange spent on advertisements, publicizing the law and/or the exchange? Did the state or the exchange use federal or state funds?

   As of April 1, 2014 total expenditures for public awareness and education were $3,543,946. All funds expended were federal establishment grants.

7. After September 31, 2013, approximately how much has been paid in bonuses to exchange employees?

   A total of $26,354 was approved in October 2013 and paid to fourteen managers for performance during the third quarter of 2013.

8. What are the estimated operational costs for the exchange in the years 2014, 2015, and 2016?

   The estimated operational cost for 2014 is $126,900,360. The estimated operational cost for 2015 is $39,761,416. Attached please find a detailed spreadsheet for MNsure's 2015 operations. We do not have a detailed budget for 2016 at this time.

   a. What revenue sources will the state utilize to finance the exchange in these years? What is the expected revenue?

      Under Minnesota law, MNsure may collect up to 3.5% of premiums on policies sold through MNsure. The authority to establish the percentage that is withheld from premiums rests with the MNsure Board of Directors. Federal rule also requires that exchanges cost-allocate Medicaid costs to the Medicaid program. MNsure will primarily rely on these two financing mechanisms going forward. The 2015 budget is balanced. It assumes no increase in rates, assumes 50,000 enrollees in commercial plans in 2014, and authority to carry forward existing establishment grant funds into calendar year 2015. To date MNsure has enrolled over 211,000 individuals and has exceeded the budgetary enrollment goal of 50,000 commercial enrollees.

   b. How will the state address any deficits in the exchange's budget?

Based on commercial enrollment through the 2014 open enrollment, MNsure is on track to meet the commercial enrollment required to have a balanced budget in 2015. To the extent there is a deficit, MNsure will live within its means and reduce or reallocate funds as needed.

c. Will the state seek any federal money to help finance the exchange's operations?

In 2014, exchanges are permitted to use federal establishment grant funds for operations. MNsure does not expect to request additional state or federal funding. MNsure is seeking authority to carry-forward previously awarded grant funds for operations in 2015.

9. Who was the state's primary point of contact at CMS?

Minnesota CCIIO State Officers Terence Kane and Stephanie Hengst.

a. Did CMS play a role in overseeing the use of federal funds in developing your exchange? Yes. What was the role?

MNsure works closely with our State Officer and Grants Officer on all grant requests. CCIIO approves all grants, rebudgeting and release for funds requests. MNsure also works with Minnesota Department of Human Services to coordinate Advanced Planning Document submissions to the Center for Medicare and Medicaid Services (CMS) for Medicaid funding related to the Exchange.

b. How did the state ensure the exchange IT build would be completed on schedule?

MNsure staff worked with its IT vendors and partner state agencies to meet the federal requirements for certification in order to launch on October 1, 2013.

10. Did the state conduct independent assessments on exchange readiness?

Yes

a. Who conducted the reports and when where they issued?

The Independent Verification and Validation (IV&V) reviews are conducted by an independent 3rd party contractor: Software Engineering Services, Inc. of Bellevue Nebraska.

Reports are issued on a quarterly basis and so far have been issued on the following dates: May 28, 2013, August 30, 2013, December 11, 2013, and March 20, 2014.

b. Who were the recipients of these readiness reports?

By contract, the recipients of the Independent Verification and Validation reports are: Center for Medicare and Medicaid Services, Center for Consumer Information and Insurance, Administration for Children and Families, USDA Food and Nutritional Service, Office of Child Support Enforcement, MN State CIO, Minnesota Department of Human Services, and MNsure.

11. When did the state first learn that the exchange build was behind schedule?

In January of 2013, CMS laid out the so-called 70/70 requirements that state exchanges were required to meet by June 2014. At that time, MNsure's focus turned to meeting the 70 requirements laid out by the federal government in order to launch on October 1, 2013. These requirements guided MNsure's efforts during 2013.

a. When did you first realize that your website would not be operational on October 1st?

Minnesota's exchange was operational on October 1, 2013 and continues to be operational. Though not without issues, at no point during the 2014 open enrollment period did the MNsure have any unscheduled, extended down time and over 211,000 Minnesotans have enrolled in health coverage.

b. When did you inform the federal government of your exchange's problems? Who did you inform?

MNsure leadership was in contact with the federal government on a regular basis regarding the status of MNsure's site since 2011 including weekly project and technical status updates and intermittent calls with various staff at Health and Human Services.

12. Who was the central individual responsible for the exchange's development?

The Executive Director, April Todd-Malmlov, was ultimately responsible for the development of the exchange. I replaced Ms. Todd-Malmlov on December 18, 2014.

a. Who decided whether to authorize the exchange to launch on October 1st?

MNsure leadership, in consultation with our vendors, security team, and partner state agencies, decided to launch MNsure on October 1, 2013.

b. What was the date in which day one specifications were finalized?

In early 2013, the federal government issued 70 requirements that exchanges must meet in order to launch on October 1, 2013. MNsure's efforts during much of 2013 were geared toward meeting these requirements. Generally speaking, exchanges are required to allow users to create an account, receive an eligibility determination, pick a plan, and pay their premium.

c. Who made the final decision what features would launch on October 1st?

MNsure leadership, in consultation with our vendors, security team, and partner state agencies, made the final decision as to what features would be included with MNsure on October 1, 2013.

13. To date, what has the state done to identify the causes of the exchange's failure on October 1st? To date, who has been held accountable for the failures experienced on October 1st? How were they held accountable?

Since taking on the role of interim CEO at MNsure, we have taken important steps to rectify urgent problems that Minnesotans have faced using the MNsure system. First, IBM/Curam, the vendor responsible for eligibility determinations, added resources to assist in resolving issues related to eligibility determinations. As a result, we have seen a substantial increase in the proportion of individuals receiving electronic and prompt determinations through MNsure as compared to December 2013. Second, errors rates across the entire IT system have dropped from approximately 17 percent in November to a current rate of 4 percent. Also, we have added significant resources to our call center and we ordered an end-to-end review of MNsure, which was performed by Optum, a division of United Health Care Group. We are moving quickly to implement the Optum recommendations with additional improvements to ensure a better customer experience.

With regard to the Optum report, we took a number of rapid steps. First, we focused on reducing call wait times and improving customer issue resolution. We contracted with APAC Customer Services based in Mendota Heights, MN, to bring on an additional 100 call center representatives all of whom were on the phone from February 26, 2014 through the end of open enrollment. Call wait times at the end of December averaged 60 minutes or more. Call wait times decreased significantly during the final months of open enrollment and averaged five minutes or less on most days.

Second, Deloitte Consulting will fill the role of lead vendor for implementing MNsure's overall improvement plan. MNsure leadership will work with Deloitte to define a mid-range plan to make the needed improvements including ensuring there is effective coordination across the vendors and their components of the online marketplace.

Third, we moved quickly following the Optum report to reinstate the IT program decision-making process that was in place and working well before October 1. The structure is made up of interagency committees and workgroups that prioritize the IT fixes and releases as well as to drive those decisions down to the vendors for implementation.

Additionally, we've made multiple organizational changes. It is our hope that the restructuring that we've undertaken will lead to a more transparent and efficient organization.

14. To date, how many people enrolled in private plans on your state exchange?

As of May 6, 2014, 50,464 individuals have enrolled in private coverage.

15. To date, how many of those enrollees have paid their first months' premium?

    Our last figures from February 2014 indicate that approximately 95 percent of individuals have paid their first month's premium.

16. To date, how many of those enrollees had previously been insured?

    We do not yet have this data but we expect to in the future.

17. How many individuals were hired to process paper applications because the website did not work? How much did this cost? Was it paid for by federal or state funds?

    Paper applications were processed by the Minnesota Department of Human Services (DHS). While the number of paper applications may have been higher due to website problems, states must accept paper applications under federal law and Minnesota planned for paper application processing. Paper applications were processed by existing DHS staff with some supplementation from temporary staff. At the peak of activity, 52 temporary staff were added to process applications and perform other tasks related to enrollment. $192,000 was spent on these staff from October 2013 through March 25, 2014. Costs were paid from the DHS budget with appropriate cost allocation to federal programs.

18. What percentage of the originally planned features of the system was expected to be functional on October 1st?

    MNsure focused on basic operations that would allow individuals to get coverage for October 1, 2013 including creating an account, shopping for a plans, enrolling in a plan, and paying the premium.

    a. What percentage of the originally planned features of the system was actually functional on October 1st?

       The core components of MNsure were functional on October 1, 2013. Portions of the software did develop issues, specifically, the IBM/Curam module, which determines an individual's eligibility for financial assistance. We have seen a substantial increase in the proportion of individuals receiving electronic and prompt determinations through MNsure largely due to the significant resources that IBM was willing to commit to improving the product. Overall, error rates across the entire IT system have dropped from approximately 17 percent in November to a current rate of 4 percent which illustrates system improvements over the course of the past several months.

    b. What percentage of the originally planned features of the system is functioning currently?

The core components of MNsure are functioning. Significant improvements have been made with respect to MNsure functionality.

c. What functions remain to be built?

MNsure will work with Deloitte and its vendors to continue to chart a course for further implementation of website enhancements. During the April 30, 2014 meeting of the MNsure Board, staff laid out a high-level estimated schedule of how MNsure could move forward. That document can be accessed at this link: https://www.mnsure.org/images/bd-2014-04-30-roadmap.pdf

19. Prior to October 1st, 2013, did the exchange reduce or postpone any planned features for the October 1st launch? Which features were descoped? When did they get descoped? How was the public made aware of these changes?

MNsure postponed features of the website prior to the October 1 launch. Those features include a medical provider look-up tool and an enrollment portal for third parties such as insurance agents and navigators. The MNsure Board had discussions at its public meetings regarding expectations, functionality, and future IT build-out and improvements. All MNsure board meetings are live-streamed over the internet as well as archived through the MNsure website.

20. Who is the program manager for the exchange? Does the program manager possess technical expertise in systems development? What is his/her expertise? (If there are multiple program managers, please list all the relevant names and titles.)

MNsure recently hired Deloitte Consulting to provide overall project management, among other responsibilities. Deloitte's response to MNsure's request for proposal for project management demonstrated significant expertise required to execute the terms of the contract.

21. At any point, did the exchange become aware of concerns that the exchange employees overseeing the project may not have the adequate technical skills to oversee the development? If so, what did the exchange do to address these concerns?

No.

22. At any point, did the exchange become aware of concerns that the contractors on the project may not have the adequate technical skills to build the system? If so, what did the exchange do to address these concerns?

MNsure executed contracts with its vendors for specific deliverables. MNsure's role was and continues to be to ensure that vendors meet their obligations under the contracts. It is incumbent on the vendors to ensure that they have the sourced the appropriate staff and expertise to deliver on the terms of the contracts.

23. According to reviews by the CMS Chief Information Security Officer's office, dated September 28, 2013, the Minnesota exchange had 110 security controls that were either not documented or incomplete. Why did Minnesota fail to document or complete so many security controls prior to October 1st?

    Based on multiple independent assessments, both internal and external, MNsure was confident that all critical security risks were addressed prior to the October 1 launch.

24. A recent report by the *Minneapolis Star-Tribune* referenced a meeting with Governor Dayton and exchange officials where "[n]o one was certain the new website built to help thousands of uninsured Minnesotans get health coverage would actually work." What was done prior to October 1st, to mitigate website readiness concerns?

    I was not in attendance at the meeting referenced by the Minneapolis Star-Tribune article and therefore do not understand the context of the discussion. Staff worked with the vendors prior to the launch to meet the requirements of federal law and rule for the October 1 launch.

25. Given the fact that MNsure has both a board of directors (appointed by Governor Dayton) and a legislative oversight committee, how could so much go so wrong so quickly without detection or notice?

    Both the MNsure board and the Legislative Oversight Committee conduct oversight pursuant to Minnesota law. I am not able to speak for the board or the Legislative Oversight Committee.

26. According to the *Minneapolis Star-Tribune*, the exchange "didn't have plans to address website failures, forcing officials to scramble when the system broke down." Why did the state not consider contingency plans given all the readiness concerns with the project?

    A paper application process was one of the deliverables that was promised by vendors. However, as the project moved forward IBM\Curam informed us that this level of functionality would not be available for large numbers of applicants when we lunched. As a result, MNsure implemented manual processes following the launch of MNsure. The manual processes matured during the course of the open enrollment period to the point that consumers now have an avenue to enroll if faced with technological issues.

27. Also according to the *Minneapolis Star-Tribune*, "Minnesota officials, who said the federal government's Oct. 1 deadline to launch the website was "inflexible," did not know that online enrollment could be postponed without penalty...." How was it communicated to Minnesota officials that the October 1 launch deadline was "inflexible?"

    Federal regulations promulgated by the Department of Health and Human Services and published in the Federal Register clearly state that a Marketplace must have an internet web site in place through which individuals can apply and enroll in coverage beginning October 1, 2014.

28. Did the State or exchange employees have any discussions with CMS officials on whether to go-live only with paper applications?

    MNsure did not explore this option.

29. The *Minneapolis Star-Tribune* also reported "MNsure board members said they were not told about critical audit findings, and were unaware of meetings during which staff members discussed postponing the launch." Why was the board not informed of key information regarding the readiness of the exchange?

    I cannot speak to how or whether the board was properly informed or kept up to date on these issues prior to my tenure at MNsure.

30. According to press reports, Optum, a contractor who conducted an assessment of the exchange system, found that fixing the site could take up to two years. One other suggestion provided by Optum was to start over. What steps will the exchange take to fix the problems with the site? Is the exchange considering starting over, as Optum suggested, and discarding the current site?

    MNsure recently selected Deloitte Consulting to provide key project management support, which is consistent with one of the recommendations in the Optum report. Deloitte will generally be responsible for the following:

    - Program and Project Management
    - Project Planning
    - Functional and Technical Systems Assessment
    - Release Management
    - Defect and Issue Tracking
    - Leadership and Planning of User Acceptance Testing

    Deloitte will advise MNsure and make recommendations to MNsure as to a course for the IT fixes and program management going forward as part of their responsibilities under the contract.

    a. How much does the state expect to spend to fix these problems?

    MNsure, with Deloitte as the project manager, is currently evaluating how to move forward. As we develop and implement a plan to move forward, any costs associated with its implementation will become clearer.

    b. Will the state request additional federal funding to fix these problems?

    MNsure does not plan to request additional federal or state funding at this time.

31. According to the *Minneapolis Star-Tribune*, "the agency is facing a nearly $2.5 million deficit next year, if enrollment trends continue as they are today and there are no major

expenditures, neither of which is likely." What is the expected deficit for next year? How does the exchange intend to resolve this deficit?

MNsure developed a 2015 budget based on an assumption of 44,000 commercial enrollment through the 2013-2014 open enrollment and 50,000 commercial enrollments by the end of 2014. MNsure has already reached 50,000 commercial enrollments for 2014. As a result, we do not expect a budget deficit for 2015.

32. Numerous reports have indicated that Minnesota inappropriately used federal Medicaid funds to cross-subsidized state health insurance plans. In your previous capacity as Assistant Commissioner at the Department of Human Services (DHS), you oversaw the investigations of such allegations. One such review included reevaluating Minnesota's long-time actuary – Milliman. In the end, Minnesota's DHS decided not to replace Milliman. Why did Minnesota's DHS decide to retain Milliman?

In April of 2013, the Department of Human Services (DHS) issued an RFP to secure a new actuary and to move away from its actuary for contract years 2003-2011, Milliman-Minneapolis. The contract that resulted from the procurement incorporates many of the findings from the various rate-setting reports.

After careful consideration, DHS chose Milliman-Milwaukee under this procurement. Milliman-Milwaukee's response to the proposal was superior to other responses. Their response best demonstrated that they understood the DHS' needs and that understanding helped them put together the best work plan to address those needs. DHS previously worked with Milliman-Milwaukee to set the 2013 rates for the PMAP families and children contract, which resulted in an average rate one percent *lower* than previous years.

While the new actuary shares a parent company with the actuary during contract years 2003-2011, after extensive review it was determined that the two offices are independent from each other both financially and in terms of personnel. Milliman-Milwaukee was not involved in setting rates for the contracts in question during 2003-2011 and, as their work on the 2013 contracts indicates, they have a proven record in helping guarantee the state receives good value in managed care contracting.

a. What role does Milliman play in the approval of MNsure products?

Milliman-Milwaukee plays no role in the approval of MNsure products.

33. Who approves the products created and offered on MNsure? What is the role of the Minnesota Council of Health Plans in the operation of MNsure?

The Qualified Health Plans (QHPs) approved for sale through MNsure must be approved by the Minnesota Department of Commerce, which ensures that the products sold on MNsure meet the standards necessary for sale in Minnesota.

The Minnesota Council of Health Plans (MCHP) has no direct role in the operations of MNsure. MCHP is an important stakeholder to MNsure and one whose input is valued relative to the operations of MNsure. Members of the MCHP participate in the Health Industry Advisory Committee which provides guidance, advice and recommendations to the Board as it carries out its mission.

34. In 2008, the same Minnesota Legislative Auditor observed clear signs of the improper cross subsidization of healthcare programs with Medicaid funds. In March of 2013, a report, commissioned by Minnesota DHS, and prepared by the Segal firm, concluded that a reasonable person should have been aware of these things[1]. When you were the assistant commissioner at DHS, the Segal report indicated serious problems in the HMOs' management of Minnesota's public healthcare programs.

    a. Did Segal produce earlier drafts of its findings to the State?

       Yes.

    b. Were earlier drafts sent to personal e-mail accounts of DHS employees, including Jim Golden and Mark Hudson?

       In my current position, I don't have access to information that would be responsive to this question. However, I've been informed by officials at the Minnesota Department of Human Services that no earlier drafts were sent to the personal e-mail accounts of DHS employees.

    c. Were steps taken to ensure that previous drafts of the Segal report would not appear at DHS or on DHS computers?

       In my current position, I don't have access to information that would be responsive to this question. However, I've been informed by officials at the Minnesota Department of Human Services that no steps were taken to ensure that drafts of the Segal report would not appear at DHS or on DHS computers. All correspondence and copies of drafts were sent to DHS email accounts.

        i. If so, what was your involvement in this?

35. According to news reports, the legislative co-chairs of the MNsure oversight committee and the MNsure board chair went on annual trips to Germany with representatives of the HMO vendors and the HMO trade association.[2]

    a. Did you also attend these trips?

       I attended the conference in Germany referenced in the news story in the footnote.

[1] http://www.publicrecordmedia.com/wpcontent/uploads/2013/04/MNDHS2013_pd_003.pdf

[2] http://kstp.com/news/stories/S3192792.shtml?cat=1

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